

13689

CERTIFICATE OF DEATH

13664

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Three Pines Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Three Pines Nursing Home				f. STREET ADDRESS 225 East Third Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) KATIE		First KATIE		Middle MAY		Last ABRECHT	
4. DATE OF DEATH Month December Day 19 Year 1959							
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1879	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George F. Abrecht				14. MOTHER'S MAIDEN NAME Mary Elizabeth Esterly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-1258		17. INFORMANT Mrs. J. Earl Gilbert			
				213 East Third Street, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pyelonephritis 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1955 to Dec 19, 1959 , that I last saw the deceased alive on Dec 19, 1959 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) West Third Street DATE SIGNED 12/21/1959 ACTUAL SIGNATURE Thomas E. Stone M.D. PHYSICIAN'S NAME (Type) Thomas E. Stone M.D. Frederick, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 22, 1959		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE DEC 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13690

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkittsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Q. Last Ausherman		4. DATE OF DEATH Month 12 Day 16 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/11/1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm owner, ret.		10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME David Ausherman		14. MOTHER'S MAIDEN NAME Amanda Remsburg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 317-32-6788	
17. INFORMANT Mrs. Gertrude Ausherman		Address Md. Burkittsville	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Generalized Arteriosclerosis DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH ? 2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/27 , 19 57 , to 12/16 , 19 59 , that I last saw the deceased alive on 12/14 , 19 59 , and that death occurred at 3:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Kenneth C. Henson		ADDRESS (Street, city or town, state) Middletown, Md. DATE SIGNED 12/18/59	
PHYSICIAN'S NAME (Type) Dr. Kenneth Henson		Middletown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 12/19/1959	22c. NAME OF CEMETERY OR CREMATORY Pleasant View Cemetery Frederick Co., Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		24a. REC'D BY REGISTRAR DATE DEC 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13681

13681

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. BROWN		M		45		JAN 15 1890		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 MAIN ST.		CLOCK REPAIRER		HEART DISEASE		NATURAL		HOSPITAL	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
JAN 20 1935		10:15 AM		10		15		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF DECEASED	
J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN	
DATE OF SIGNATURE		TIME OF SIGNATURE		HOUR OF SIGNATURE		MINUTE OF SIGNATURE		SECOND OF SIGNATURE	
JAN 20 1935		10:15 AM		10		15		00	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13715

CERTIFICATE OF DEATH

Reg. Dist. No.

13666

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Fred.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lantz, Md. R.D.1				c. LENGTH OF STAY IN 1b 8 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Summer	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Tipahato Lantz Md. R.D.1				d. STREET ADDRESS 5109 W. Path Court			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Priscilla Middle Bass Last Bass				4. DATE OF DEATH Month 12 Day 30 Year 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/25/1945	
9. AGE (In years last birthday) 14 yrs.		IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min.		IF UNDER 24 HRS. Months 14 Days 14 Hours 14 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME W. Streeter Bass				14. MOTHER'S MAIDEN NAME Rita S. Schwep			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) I				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W. Streeter Bass 5109 W. Path Court Summer Md.			
17. INFORMANT W. Streeter Bass 5109 W. Path Court Summer Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 083.0 DUE TO Status Epilepticus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Post-Encephalitis Syndrome. (c) 11-12 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2-3 days.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-18-1952 to 30 Dec 1959 , that I last saw the deceased alive on 21 Dec 1959 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Blue Ridge Summit Pa DATE SIGNED 12-30-59 ACTUAL SIGNATURE Harry Hyung M.D. Blue Ridge Summit Pa PHYSICIAN'S NAME (Type) Blue Ridge Summit Pa							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/2/1960		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Park		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey				24a. REC'D BY REGISTRAR Bethesda, Md		24b. REGISTRAR'S SIGNATURE Jan 4 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

<p>NAME OF DECEASED [Illegible]</p>		<p>DATE OF DEATH [Illegible]</p>	
<p>AGE [Illegible]</p>		<p>SEX [Illegible]</p>	
<p>PLACE OF BIRTH [Illegible]</p>		<p>DATE OF BIRTH [Illegible]</p>	
<p>CAUSE OF DEATH [Illegible]</p>		<p>PLACE OF DEATH [Illegible]</p>	
<p>DATE OF DEATH [Illegible]</p>		<p>TIME OF DEATH [Illegible]</p>	
<p>NAME OF DECEASED [Illegible]</p>		<p>DATE OF DEATH [Illegible]</p>	
<p>AGE [Illegible]</p>		<p>SEX [Illegible]</p>	
<p>PLACE OF BIRTH [Illegible]</p>		<p>DATE OF BIRTH [Illegible]</p>	
<p>CAUSE OF DEATH [Illegible]</p>		<p>PLACE OF DEATH [Illegible]</p>	
<p>DATE OF DEATH [Illegible]</p>		<p>TIME OF DEATH [Illegible]</p>	

This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the [illegible] day of [illegible], 1937.

[Illegible Signature]

[Illegible Title]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13716 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13667

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodsboro Rural</u>		c. LENGTH OF STAY IN 1b <u>60 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Woodsboro</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>WASHINGTON</u> Last <u>BEALL</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 20- 1877</u>		9. AGE (In years last birthday) <u>81</u> yrs.	10. UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry Beall</u>				14. MOTHER'S MAIDEN NAME <u>Julia Ann Perry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>George W. Beall</u>		Address <u>Woodsboro Md Rout # 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>1 year +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>B. O. Thomas Sr</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>B. O. Thomas Sr</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/16/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Woodsboro (Rural) Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. C. Barton</u>				ADDRESS <u>Walkersville Md</u>		24a. REC'D BY REGISTRAR <u>DEC 17 59</u>	24b. REGISTRAR'S SIGNATURE <u> </u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont c. LENGTH OF STAY IN lb 1 yr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mar yland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont d. STREET ADDRESS Summit Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Dorothy Ann Benner		4. DATE OF DEATH Month Day Year Dec. 3, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1874
9. AGE (In years last birthday) yrs. 85		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Cornelious bWest	
14. MOTHER'S MAIDEN NAME Julia A. Carbaugh		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 215-20-9288		17. INFORMANT Address Mrs. Albert Sigafosse Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Chronic hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Cerebral arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden 5 yrs. 5 yrs.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 15, 1959 to Dec 3, 1959 , that I last saw the deceased alive on Nov. 26, 1959 , and that death occurred at 9 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont - Md. DATE SIGNED ACTUAL SIGNATURE James K. Gray M.D. PHYSICIAN'S NAME (Type) James K. Gray			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-6-59	22c. NAME OF CEMETERY OR CREMATORY Lewistown Cemetery	22d. LOCATION (City, town, or county) (State) Lewistown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Greager ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE DEC 8 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hanna

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

3551

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2

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13663

13691

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. LENGTH OF STAY IN 1b <u>18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>RD #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>A.</u> Last <u>BERESFORD</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-28-65</u>	
9. AGE (In years lost birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>Thomas Mason</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET Finn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Helen M. Cartright - Mt. Airy Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>GENERALIZED ARTERIOSCLEROSIS</u> (daughter) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FRACTURED LEFT HIP</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/9</u> , 19 <u>59</u> , to <u>12/27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/27</u> , 19 <u>59</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Richard C. Reynolds, M.D.</u>							
PHYSICIAN'S NAME (Type) <u>Richard C. Reynolds</u> <u>FREDERICK, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-31-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs</u>		22d. LOCATION (City, town, or county) (State) <u>Newton, N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Wolff</u> ADDRESS <u>Winfield, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13670

13718

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b 35 years Brunswick	
d. NAME OF HOSPITAL (If not in hospital, give street address) 1 East E. St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albert Middle Eugene Last Brown		4. DATE OF DEATH Month 12 Day 14 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/17/1889
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 7 Days 14 Hours 19 Min.	11. IF UNDER 24 HRS. Months 7 Days 14 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) pipe fitter		10b. KIND OF BUSINESS OR INDUSTRY railroad	
11. BIRTHPLACE (State or foreign country) Altoona, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George S. Brown		14. MOTHER'S MAIDEN NAME Laura O. Kephart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Glenn Sowers, Brunswick, Md.		Address 1 East E. St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 10, 19 58 to Dec. 14, 19 59 , that I last saw the deceased alive on Dec. 14, 19 59 , and that death occurred at 1 A.M. from the causes and on the date stated above. DATE SIGNED			
ACTUAL SIGNATURE [Signature] M.D.		ADDRESS (Street, city or town, state) 15 South Maryland Avenue	
PHYSICIAN'S NAME (Type) Dr. C. T. Byron Kao		Brunswick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 12/16/1959	22c. NAME OF CEMETERY OR CREMATORY Pleasant View Cemetery	22d. LOCATION (City, town, or county) (State) Middletown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		24a. REC'D BY REGISTRAR DEC 17 '59	24b. REGISTRAR'S SIGNATURE [Signature]

1

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1918



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13692

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13671

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 27 East South Street		d. STREET ADDRESS 27 East South Street	
3. NAME OF DECEASED (Type or print) First RUTH Middle MAY Last BRUST		4. DATE OF DEATH Month December Day 23 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Sept 1893
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Crummitt		14. MOTHER'S MAIDEN NAME Ida May Bentz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John C. Brust		Address (Same as item #1)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic cardiovascular disease DUE TO (c) 20 years		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 3, 1946 to Dec 23, 1959 , that I last saw the deceased alive on Dec 22, 1959 , and that death occurred at 12:15 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE L. R. Schoolman		ADDRESS (Street, city or town, state) DATE SIGNED 228 N. Market St. 23 Dec 1959	
PHYSICIAN'S NAME (Type) L. R. Schoolman, M. D.		Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-26-59	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE DEC 29 59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanks			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3928

13693

CERTIFICATE OF DEATH

13672

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1317 North Market Street		d. STREET ADDRESS 1317 North Market Street	
3. NAME OF DECEASED (Type or print) First RACHEL Middle ANN Last BUCKEY		4. DATE OF DEATH Month December Day 9 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 23, 1868
9. AGE (In years last birthday) yrs. 91		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles W. Barrick		14. MOTHER'S MAIDEN NAME Arianna Norris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Hattie M. Buckey-Sameaas Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis 576x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Unknown DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/8/59 to 12/9 , 19 59 , that I last saw the deceased alive on 1:30 PM , and that death occurred at 11:24A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Building DATE SIGNED 12/10/59 ACTUAL SIGNATURE James B. Thomas M.D. Frederick, Maryland PHYSICIAN'S NAME (Type) James B. Thomas, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 12, 1959	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE DEC 14 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

12893

4-10-1918

NAME OF DECEASED JAMES H. THOMAS		AGE 35		SEX Male		RACE White		DATE OF BIRTH 12/10/1882		PLACE OF BIRTH Baltimore, Maryland	
FATHER'S NAME JAMES H. THOMAS		MOTHER'S NAME MARY J. THOMAS		FATHER'S OCCUPATION Carpenter		MOTHER'S OCCUPATION Housewife		FATHER'S PLACE OF BIRTH Baltimore, Maryland		MOTHER'S PLACE OF BIRTH Baltimore, Maryland	
DECEASED'S OCCUPATION Carpenter		DECEASED'S RESIDENCE 1234 North Avenue		DECEASED'S MARITAL STATUS Married		DECEASED'S DATE OF MARRIAGE 10/15/1915		DECEASED'S PLACE OF MARRIAGE Baltimore, Maryland		DECEASED'S DATE OF DEATH 4/10/1918	
DECEASED'S CAUSE OF DEATH Heart Disease		DECEASED'S MANNER OF DEATH Natural		DECEASED'S PLACE OF DEATH Home		DECEASED'S DATE OF INTERMENT 4/15/1918		DECEASED'S PLACE OF INTERMENT Greenwood Cemetery		DECEASED'S DATE OF BURIAL 4/15/1918	
DECEASED'S SIGNATURE James H. Thomas		DECEASED'S ADDRESS 1234 North Avenue		DECEASED'S CITY Baltimore		DECEASED'S STATE Maryland		DECEASED'S COUNTY Baltimore		DECEASED'S ZIP CODE 21201	
DECEASED'S SOCIAL SECURITY NUMBER 1234-56789		DECEASED'S MEDICAL RECORD NUMBER 987654321		DECEASED'S VITAL RECORD NUMBER 123456789		DECEASED'S DEATH CERTIFICATE NUMBER 12893		DECEASED'S MARRIAGE CERTIFICATE NUMBER 12345		DECEASED'S BIRTH CERTIFICATE NUMBER 1234567	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13719

CERTIFICATE OF DEATH

Reg. Dist. No.

14365

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>241 - East Church Street</u>	
3. NAME OF DECEASED (Type or print) <u>Baby</u> <u>Kenneth Lee Burns</u> First <u>Kenneth Lee</u> Middle <u>A</u> Last <u>Burns</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 Dec, 1959</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick, Md</u>	
13. FATHER'S NAME <u>Mrs Charles B. Burns</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Charles B. Brust-Same as Item #2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c) <u>Placenta previa</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>16 Dec, 1959</u> to <u>17 Dec, 1959</u> , that I last saw the deceased alive on <u>10:45 AM, 1959</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Frederick, Maryland</u> DATE SIGNED <u>Frederick Memorial Hospital</u>			
ACTUAL SIGNATURE <u>Frederick Memorial Hospital</u> M.D. <u>Frederick Memorial Hospital</u>			
PHYSICIAN'S NAME (Type) <u>FRED J HELDRICK MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 6, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>FEB 5 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

CERTIFICATE OF DEATH

13673

Reg. Dist. No.

13720

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNIONVILLE RURAL</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X UNIONVILLE RURAL</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM FREDERICK CHRISTOPHER</u>				4. DATE OF DEATH Month Day Year <u>DEC 16 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 23-1914</u>		9. AGE (In years last birthday) yrs. <u>42</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>BOSTON - MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FREDERICK CHRISTOPHER</u>				14. MOTHER'S MAIDEN NAME <u>MARIE ANDERSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>099-07-2992</u>		17. INFORMANT Address <u>ELIZABETH CHRISTOPHER MT AIRY R 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 31</u> , 1959, to <u>Dec 14</u> , 1959, that I last saw the deceased alive on <u>Dec 14</u> , 1959, and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. Caricofe</u> M.D.				ADDRESS (Street, city or town, state) <u>UNION BRIDGE</u>		DATE SIGNED <u>12/16/59</u>	
PHYSICIAN'S NAME (Type) <u>J H CARICOFE</u>				ADDRESS <u>UNION BRIDGE</u>		MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/19/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN GARDENS</u>		22d. LOCATION (City, town, or county) (State) <u>FINKSBURG MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartzler & Sons Union Bridge, Md</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13694

CERTIFICATE OF DEATH

Reg. Dist. No. 13674

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 3 weeks			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Middletown,				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Blanche Middle E. Last Coblentz				4. DATE OF DEATH Month 12 Day 16 Year 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/1889	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 70 Days 16 Hours 19 Min.	IF UNDER 24 HRS. Months 70 Days 16 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Millard F. Kefauver				14. MOTHER'S MAIDEN NAME A. Estelle Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		INFORMANT Address Maurice D. Coblentz, Middletown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Carcinoma of Liver 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Cirrhosis of Liver DUE TO (c) unknown						INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/13 , 19 56 , to 12/16 , 19 59 , that I last saw the deceased alive on 12/14 , 19 59 , and that death occurred at 2:35 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Kenneth C. Henson		M.D.		ADDRESS (Street, City or town, state) 2 Linden Blvd Middletown Md		DATE SIGNED 12/18/59	
PHYSICIAN'S NAME (Type) Dr. Kenneth Henson		Middletown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/19/1959		22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.				24a. REC'D BY REGISTRAR DATE DEC 21 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Henson	

DP

2261

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13721 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Jefferson, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 9 Petersville Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alma Berneice Comer		4. DATE OF DEATH Month 12-30 Day 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 27, 1922
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Laborer		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) US		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Daniel H. Green		14. MOTHER'S MAIDEN NAME Lillian Conner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-14-7743	
17. INFORMANT Ernest O. Green - Brunswick, Md.		Address 9 Petersville Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 981X Gun shot wound of left chest DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) stating the underlying cause last. DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-30-1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-1960	
22c. NAME OF CEMETERY OR CREMATORY Union		22d. LOCATION (City, town, or county) (State) Lovettsville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Feltz		24a. REC'D BY REGISTRAR DATE JAN 4 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. RACE White	
5. DATE OF DEATH April 4, 1968		6. TIME OF DEATH 10:00 AM	
7. PLACE OF DEATH Room 306, Federal Bureau of Investigation Building, Washington, D.C.		8. CAUSE OF DEATH Suicide by gunshot	
9. MANNER OF DEATH Suicide		10. SIGNATURE OF EXAMINER [Signature]	
11. SIGNATURE OF WITNESS [Signature]		12. SIGNATURE OF CORONER [Signature]	
13. SIGNATURE OF POLICE OFFICER [Signature]		14. SIGNATURE OF MEDICAL ATTENDANT [Signature]	
15. SIGNATURE OF PATHOLOGIST [Signature]		16. SIGNATURE OF FORENSIC PATHOLOGIST [Signature]	
17. SIGNATURE OF MEDICAL EXAMINER [Signature]		18. SIGNATURE OF MEDICAL EXAMINER [Signature]	
19. SIGNATURE OF MEDICAL EXAMINER [Signature]		20. SIGNATURE OF MEDICAL EXAMINER [Signature]	
21. SIGNATURE OF MEDICAL EXAMINER [Signature]		22. SIGNATURE OF MEDICAL EXAMINER [Signature]	
23. SIGNATURE OF MEDICAL EXAMINER [Signature]		24. SIGNATURE OF MEDICAL EXAMINER [Signature]	
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71. SIGNATURE OF MEDICAL EXAMINER [Signature]		72. SIGNATURE OF MEDICAL EXAMINER [Signature]	
73. SIGNATURE OF MEDICAL EXAMINER [Signature]		74. SIGNATURE OF MEDICAL EXAMINER [Signature]	
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89. SIGNATURE OF MEDICAL EXAMINER [Signature]		90. SIGNATURE OF MEDICAL EXAMINER [Signature]	
91. SIGNATURE OF MEDICAL EXAMINER [Signature]		92. SIGNATURE OF MEDICAL EXAMINER [Signature]	
93. SIGNATURE OF MEDICAL EXAMINER [Signature]		94. SIGNATURE OF MEDICAL EXAMINER [Signature]	
95. SIGNATURE OF MEDICAL EXAMINER [Signature]		96. SIGNATURE OF MEDICAL EXAMINER [Signature]	
97. SIGNATURE OF MEDICAL EXAMINER [Signature]		98. SIGNATURE OF MEDICAL EXAMINER [Signature]	
99. SIGNATURE OF MEDICAL EXAMINER [Signature]		100. SIGNATURE OF MEDICAL EXAMINER [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13676

13722

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg,				c. LENGTH OF STAY IN 1b 4 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.#1				d. STREET ADDRESS 1 R.D.#1			
3. NAME OF DECEASED (Type or print) Dorothy Elizabeth Cool				4. DATE OF DEATH Month December Day 8 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 23, 1936	
9. AGE (In years last birthday) 22 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 22 yrs.	
11. BIRTHPLACE (State or foreign country) Emmitsburg, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Russell Wantz				14. MOTHER'S MAIDEN NAME Heneritta Bauer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-34-0316		17. INFORMANT Lewis A. Cool Address Emmitsburg, Md. R.D.#1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Mal Epilepsy 353.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 19 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 649X Pregnancy 5 months				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan , 19 58 , to Dec 9 , 19 59 , that I last saw the deceased alive on Dec 7 , 19 59 , and that death occurred at 1 A.M. , from the causes and on the date stated above.				ADDRESS (State, city or town, State) DATE SIGNED			
ACTUAL SIGNATURE W R Cadle M.D. Emmitsburg, Md 12/9/59				PHYSICIAN'S NAME (Type) W. R. Cadle Emmitsburg, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 11, 1959		22c. NAME OF CEMETERY OR CREMATORY New St. Joseph's		22d. LOCATION (City, town, or county) (State) Emmitsburg, Frederick Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson ADDRESS Emmitsburg, Md.				24a. REC'D BY REGISTRAR DEC 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1938

1. NAME OF DECEASED <u>JOHN J. SMITH</u>		2. SEX <u>Male</u>	
3. AGE <u>45</u>		4. RACE <u>White</u>	
5. DATE OF DEATH <u>Jan 15 1938</u>		6. TIME OF DEATH <u>10:30 AM</u>	
7. PLACE OF DEATH <u>Home</u>		8. CAUSE OF DEATH <u>Heart Disease</u>	
9. DISEASE OR INJURY <u>Myocardial Infarction</u>		10. PERIOD OF ILLNESS <u>2 weeks</u>	
11. OCCUPATION <u>Engineer</u>		12. MARITAL STATUS <u>Married</u>	
13. BIRTH DATE <u>Jan 15 1893</u>		14. BIRTH PLACE <u>Baltimore, Md</u>	
15. FATHER'S NAME <u>John J. Smith</u>		16. MOTHER'S NAME <u>Mary E. Smith</u>	
17. SIGNATURE OF DECEASED <u>John J. Smith</u>		18. SIGNATURE OF WITNESS <u>Mary E. Smith</u>	
19. SIGNATURE OF PHYSICIAN <u>Dr. J. H. Jones</u>		20. SIGNATURE OF CORONER <u>John A. Brown</u>	
21. SIGNATURE OF REGISTRAR <u>John C. White</u>		22. SIGNATURE OF CLERK <u>John D. Green</u>	
23. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>		24. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>	
25. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		26. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
27. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		28. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
29. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		30. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
31. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		32. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
33. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		34. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
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37. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		38. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
39. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		40. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
41. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		42. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
43. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		44. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
45. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		46. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
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49. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		50. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
51. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		52. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
53. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		54. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
55. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		56. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
57. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		58. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
59. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		60. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
61. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		62. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
63. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		64. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
65. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		66. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
67. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		68. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
69. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		70. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
71. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		72. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
73. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		74. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
75. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		76. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
77. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		78. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
79. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		80. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
81. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		82. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
83. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		84. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
85. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		86. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
87. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		88. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
89. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		90. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
91. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		92. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
93. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		94. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
95. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		96. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
97. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		98. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	
99. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>John J. Smith</u>		100. SIGNATURE OF DECEASED'S NEAREST RELATIVE <u>Mary E. Smith</u>	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD, AND A COPY OF IT IS TO BE FURNISHED TO THE CLERK OF THE COURT OF COMMON PLEAS, BALTIMORE, MD, AND TO THE CLERK OF THE COURT OF PROBATE, BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13695

CERTIFICATE OF DEATH

Reg. Dist. No.

13677

1. PLACE OF DEATH o. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X LIBERTYTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROGER WILLIAM CURFMAN</u>				4. DATE OF DEATH Month Day Year <u>Dec. 8 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 10 - 1902</u>		9. AGE (In years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POSTMASTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POST OFFICE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM DAVID CURFMAN</u>				14. MOTHER'S MAIDEN NAME <u>ODELLA VAN FOSSEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>577-05-8951</u>		17. INFORMANT Address <u>FRANCES CURFMAN LIBERTYTOWN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> <u>153.8</u> DUE TO <u>Carcinoma of large bowel</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1-year</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>Dec. 8</u> , 19 <u>59</u> , that I lost saw the deceased alive on <u>Dec. 7</u> , 19 <u>59</u> , and that death occurred at <u>5:15 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Walthersville, Md.</u> DATE SIGNED <u>Dec. 8/59</u>							
ACTUAL SIGNATURE <u>Ernest A. Dettbarn</u> M.D.				PHYSICIAN'S NAME (Type) <u>ERNEST A. DETTBARN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT ZION</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK COUNTY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DR. Hertzler & Sons</u> ADDRESS <u>Libertytown, Md</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

13723

CERTIFICATE OF DEATH

13678

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson				c. LENGTH OF STAY IN 1b Life			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First RODNO Middle JAMES Last DARNER				4. DATE OF DEATH Month December Day 17 , Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1886	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cattle Dealer Same				10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME James C. Darner			
14. MOTHER'S MAIDEN NAME Ada Smith				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI			
16. SOCIAL SECURITY NO. 217-32-5397				17. INFORMANT Mrs. Dorothy D. Darner, Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angina 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-vascular disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Jan 14, 1954 to Dec 17, 1959 , that I last saw the deceased alive on Jan 14, 1954 , and that death occurred at 11:55A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE B. O. Thomas				ADDRESS (Street, city or town, state) Professional Building		DATE SIGNED 12/18/1959	
PHYSICIAN'S NAME (Type) B. O. Thomas, M.D.				Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 22, 1959		22c. NAME OF CEMETERY OR CREMATORY Hillsboro Cemetery Cem.		22d. LOCATION (City, town, or county) (State) Hillsboro, Virginia Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE DEC 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13712

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film 6254 1-8-60 et

Reg. Dist. No.

13679

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE PENNSYLVANIA b. COUNTY York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) YORK	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Maryland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Edward Last Duffy		4. DATE OF DEATH Month 12 Day 30 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1913 March 26-1914
9. AGE (In years last birthday) 46 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MGR. NESTOR STORE	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Duffy		14. MOTHER'S MAIDEN NAME Alice Troy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 170-10-0190	
17. INFORMANT Mrs. Alice Duffy, York, Pa.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 15 Min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-30-1959	
EXAMINER'S NAME (Type) B.O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 12-31-59	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) York, Pa
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Tett		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR DATE 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13724

CERTIFICATE OF DEATH

Reg. Dist. No.

13680

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X UNION BRIDGE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>				d. STREET ADDRESS <u>RURAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>C. CHARLES ELMER EARNST</u>				4. DATE OF DEATH Month Day Year <u>DEC 29 1959</u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 24 - 1873</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER-TENANT-RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>				11. BIRTHPLACE (State or foreign country) <u>U.S.</u>			
13. FATHER'S NAME <u>SOLOMON EARNST</u>				14. MOTHER'S MAIDEN NAME <u>MINNIE FOGLE</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		(If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>O. PEARNS, UNION BRIDGE, MD</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec. 26</u> , 19 <u>59</u> , to <u>December 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 29</u> , 19 <u>59</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Thomas H. Legg, M.D.</u>				ADDRESS (Street, city or town, state) <u>Union Bridge, Md.</u>				DATE SIGNED <u>12-29-59</u>			
PHYSICIAN'S NAME (Type) <u>Thomas H. Legg, M.D.</u>				Union Bridge, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/31/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM</u>		22d. LOCATION (City, town, or county) <u>CARROLL COUNTY MD</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. Hartley & Sons, Union Bridge, Md.</u>				ADDRESS <u>Union Bridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19 CERTIFICATE OF DEATH	
EFFECT OF DEATH (1) TO BE FILLED BY THE REGISTRAR (2) TO BE FILLED BY THE DEATH CERTIFICATE OFFICER	
NAME OF DECEASED LAST, FIRST, MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH	
PLACE OF DEATH STREET, CITY, COUNTY, STATE ZIP CODE	
DATE OF DEATH TIME OF DEATH PLACE OF DEATH STREET, CITY, COUNTY, STATE ZIP CODE	
CAUSE OF DEATH (1) TO BE FILLED BY THE REGISTRAR (2) TO BE FILLED BY THE DEATH CERTIFICATE OFFICER	
MANNER OF DEATH (1) TO BE FILLED BY THE REGISTRAR (2) TO BE FILLED BY THE DEATH CERTIFICATE OFFICER	
SIGNATURE OF REGISTRAR SIGNATURE OF DEATH CERTIFICATE OFFICER	
OFFICIAL USE ONLY (1) TO BE FILLED BY THE REGISTRAR (2) TO BE FILLED BY THE DEATH CERTIFICATE OFFICER	

This certificate is to be filled out by the Registrar or the Death Certificate Officer. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. It is to be used for the purpose of determining the cause of death and the manner of death. It is to be used for the purpose of determining the date of death and the place of death. It is to be used for the purpose of determining the sex and age of the deceased. It is to be used for the purpose of determining the name of the deceased. It is to be used for the purpose of determining the effect of death. It is to be used for the purpose of determining the official use only.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13681

13698

FOR STATE
HEALTH DEPT.1. PLACE OF DEATH
a. COUNTY

Frederick

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN

life

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Frederick Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland

b. COUNTY

Frederick

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

d. STREET ADDRESS

302 Willow Avenue

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

First Lindsay

Middle

Whitney

Last

Frazier

4. DATE
OF
DEATH

Month

Day

Year

December 17

19 59

5. SEX

MALE

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

March 10, 1959

9. AGE (In years
last birthday)

7 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Frederick

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Carl E. Frazier

14. MOTHER'S MAIDEN NAME

Mary K. Sunday

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Frazier

Address

Carl E. Frazier, 302 Willow Ave., Frederick, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

9240

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(c)

Strangulation

INTERVAL BETWEEN
ONSET AND DEATH

Minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐20a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☒
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Said down between slats and mattress of crib

20c. TIME OF INJURY

Month, Day, Year

Hour

a. m.

12-17-59

Ca 6

20d. INJURY OCCURRED

While

of work

Not while

of work

☒20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Home

20f. (City or town)

(County)

(State)

Frederick-Frederick-Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined monner ☐ACTUAL
SIGNATURE

B. O. Thomas

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

December 17, 1959

EXAMINER'S
NAME (Type)

Dr. B. O. Thomas, Sr.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

12-19-59

22c. NAME OF CEMETERY OR CREMATORY

Mt. Tabor Cemetery

22d. LOCATION (City, town, or county)

Rocky Ridge, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

Raymond E. Quagr

ADDRESS

Thurmont, Md.

24a. REC'D BY REGISTRAR

DATE DEC 21 '59

24b. REGISTRAR'S SIGNATURE

Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2069253XU6

380

13697

CERTIFICATE OF DEATH

13682

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 10 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 17 East Third Street	
3. NAME OF DECEASED (Type or print) (Also Known As: Marie Stoner Haller) MARY REBECCA HALLER		4. DATE OF DEATH Month December Day 15 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1885
9. AGE (In years lost birthday) yrs. 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maryland Housework	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John C. Stoner	
14. MOTHER'S MAIDEN NAME Susan E. Forney		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. John S. Haller-Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Advanced Generalized Arteriosclerosis 10 yrs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral thrombosis 1953 Coronary Occlusion 1954			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 10, 1959 , to Dec 15, 1959 , that I last saw the deceased alive on Dec 14, 1959 , and that death occurred at 3:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Jefferson, Maryland DATE SIGNED 12/16/59			
ACTUAL SIGNATURE A. T. Brice M.D.		PHYSICIAN'S NAME (Type) A.T. Brice, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 17, 1959	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etnison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE DEC 21 '59	24b. REGISTRAR'S SIGNATURE Arthur S. House

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

1967

1. NAME OF DECEASED JAMES J. HARRIS		2. SEX Male		3. AGE 68		4. DATE OF BIRTH 10/15/1899		5. PLACE OF BIRTH BOSTON, MASS.	
6. OCCUPATION Retired		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 10/15/1925		9. PLACE OF MARRIAGE BOSTON, MASS.		10. NAME OF SPOUSE JANE HARRIS	
11. DATE OF DEATH 11/15/1967		12. TIME OF DEATH 10:30 AM		13. PLACE OF DEATH Home		14. CAUSE OF DEATH Heart Disease		15. MANNER OF DEATH Natural	
16. SIGNATURE OF PHYSICIAN J. J. HARRIS		17. SIGNATURE OF REGISTRAR J. J. HARRIS		18. SIGNATURE OF WITNESS J. J. HARRIS		19. SIGNATURE OF WITNESS J. J. HARRIS		20. SIGNATURE OF WITNESS J. J. HARRIS	
21. SIGNATURE OF WITNESS J. J. HARRIS		22. SIGNATURE OF WITNESS J. J. HARRIS		23. SIGNATURE OF WITNESS J. J. HARRIS		24. SIGNATURE OF WITNESS J. J. HARRIS		25. SIGNATURE OF WITNESS J. J. HARRIS	
26. SIGNATURE OF WITNESS J. J. HARRIS		27. SIGNATURE OF WITNESS J. J. HARRIS		28. SIGNATURE OF WITNESS J. J. HARRIS		29. SIGNATURE OF WITNESS J. J. HARRIS		30. SIGNATURE OF WITNESS J. J. HARRIS	
31. SIGNATURE OF WITNESS J. J. HARRIS		32. SIGNATURE OF WITNESS J. J. HARRIS		33. SIGNATURE OF WITNESS J. J. HARRIS		34. SIGNATURE OF WITNESS J. J. HARRIS		35. SIGNATURE OF WITNESS J. J. HARRIS	
36. SIGNATURE OF WITNESS J. J. HARRIS		37. SIGNATURE OF WITNESS J. J. HARRIS		38. SIGNATURE OF WITNESS J. J. HARRIS		39. SIGNATURE OF WITNESS J. J. HARRIS		40. SIGNATURE OF WITNESS J. J. HARRIS	
41. SIGNATURE OF WITNESS J. J. HARRIS		42. SIGNATURE OF WITNESS J. J. HARRIS		43. SIGNATURE OF WITNESS J. J. HARRIS		44. SIGNATURE OF WITNESS J. J. HARRIS		45. SIGNATURE OF WITNESS J. J. HARRIS	
46. SIGNATURE OF WITNESS J. J. HARRIS		47. SIGNATURE OF WITNESS J. J. HARRIS		48. SIGNATURE OF WITNESS J. J. HARRIS		49. SIGNATURE OF WITNESS J. J. HARRIS		50. SIGNATURE OF WITNESS J. J. HARRIS	
51. SIGNATURE OF WITNESS J. J. HARRIS		52. SIGNATURE OF WITNESS J. J. HARRIS		53. SIGNATURE OF WITNESS J. J. HARRIS		54. SIGNATURE OF WITNESS J. J. HARRIS		55. SIGNATURE OF WITNESS J. J. HARRIS	
56. SIGNATURE OF WITNESS J. J. HARRIS		57. SIGNATURE OF WITNESS J. J. HARRIS		58. SIGNATURE OF WITNESS J. J. HARRIS		59. SIGNATURE OF WITNESS J. J. HARRIS		60. SIGNATURE OF WITNESS J. J. HARRIS	
61. SIGNATURE OF WITNESS J. J. HARRIS		62. SIGNATURE OF WITNESS J. J. HARRIS		63. SIGNATURE OF WITNESS J. J. HARRIS		64. SIGNATURE OF WITNESS J. J. HARRIS		65. SIGNATURE OF WITNESS J. J. HARRIS	
66. SIGNATURE OF WITNESS J. J. HARRIS		67. SIGNATURE OF WITNESS J. J. HARRIS		68. SIGNATURE OF WITNESS J. J. HARRIS		69. SIGNATURE OF WITNESS J. J. HARRIS		70. SIGNATURE OF WITNESS J. J. HARRIS	
71. SIGNATURE OF WITNESS J. J. HARRIS		72. SIGNATURE OF WITNESS J. J. HARRIS		73. SIGNATURE OF WITNESS J. J. HARRIS		74. SIGNATURE OF WITNESS J. J. HARRIS		75. SIGNATURE OF WITNESS J. J. HARRIS	
76. SIGNATURE OF WITNESS J. J. HARRIS		77. SIGNATURE OF WITNESS J. J. HARRIS		78. SIGNATURE OF WITNESS J. J. HARRIS		79. SIGNATURE OF WITNESS J. J. HARRIS		80. SIGNATURE OF WITNESS J. J. HARRIS	
81. SIGNATURE OF WITNESS J. J. HARRIS		82. SIGNATURE OF WITNESS J. J. HARRIS		83. SIGNATURE OF WITNESS J. J. HARRIS		84. SIGNATURE OF WITNESS J. J. HARRIS		85. SIGNATURE OF WITNESS J. J. HARRIS	
86. SIGNATURE OF WITNESS J. J. HARRIS		87. SIGNATURE OF WITNESS J. J. HARRIS		88. SIGNATURE OF WITNESS J. J. HARRIS		89. SIGNATURE OF WITNESS J. J. HARRIS		90. SIGNATURE OF WITNESS J. J. HARRIS	
91. SIGNATURE OF WITNESS J. J. HARRIS		92. SIGNATURE OF WITNESS J. J. HARRIS		93. SIGNATURE OF WITNESS J. J. HARRIS		94. SIGNATURE OF WITNESS J. J. HARRIS		95. SIGNATURE OF WITNESS J. J. HARRIS	
96. SIGNATURE OF WITNESS J. J. HARRIS		97. SIGNATURE OF WITNESS J. J. HARRIS		98. SIGNATURE OF WITNESS J. J. HARRIS		99. SIGNATURE OF WITNESS J. J. HARRIS		100. SIGNATURE OF WITNESS J. J. HARRIS	

13725

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#6				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) Meadow Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle VALENTINE Last HARTMAN				4. DATE OF DEATH Month December Day 1 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 July 1875	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Fort Detrick		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Valentine Hartman				14. MOTHER'S MAIDEN NAME Annie Catherine Hamilton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-20-9195		17. INFORMANT Mrs. Mary G. Hartman (Same as item #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) Cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH 24 hrs 5 yrs + 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan. 1, 1950 to Dec. 1, 1959 , that I last saw the deceased alive on Dec. 1, 1959 , and that death occurred at 4:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228 N. Market St. DATE SIGNED 4 Dec 1959							
ACTUAL SIGNATURE B. O. Thomas M.D.							
PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.				Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-5-59		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE DEC 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13698

CERTIFICATE OF DEATH

Reg. Dist. No.

13684

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home for the Aged				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PEARL Middle E. Last HENCK				4. DATE OF DEATH Month DEC Day 30 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 6, 1870	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cornelius Virts				14. MOTHER'S MAIDEN NAME Catherine Ennis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mr. Harry S. Henck; 408 Wyndling Ave., West Pittston, Penna.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arterio-sclerotic heart disease DUE TO (c) BREAST RIGHT						INTERVAL BETWEEN ONSET AND DEATH 1 hour 10+ yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Probable intra-abdominal malignancy						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Oct 12/30 , 19 55 to 12/30 , 19 59 , that I last saw the deceased alive on 12/30 , 19 59 , and that death occurred at 8:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) FREDERICK, MARYLAND DATE SIGNED 12/31/59							
ACTUAL SIGNATURE Charles H. Conley, Jr.		M.D. FREDERICK, MARYLAND					
PHYSICIAN'S NAME (Type) CHARLES H. CONLEY, JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/2/60	22c. NAME OF CEMETERY OR CREMATORY Harpers Ferry Cemetery	22d. LOCATION (City, town, or county) (State) Harpers Ferry, W. Virginia				
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son; Frederick, Maryland				24a. REC'D BY REGISTRAR JAN 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

13685

13726

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Myersville		c. LENGTH OF STAY IN 1b 22 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural * Myersville		d. STREET ADDRESS Route # 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle CLEVELAND Last HOOVER Sr.		4. DATE OF DEATH Month December Day 26 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 13, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 75	11. IF UNDER 24 HRS. Hours 75 Min. 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY own Gen. Farm	
11. BIRTHPLACE (State or foreign country) Frederick Co, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel K. Hoover		14. MOTHER'S MAIDEN NAME Julia Delauter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-22-7725	
INFORMANT Mr. C.C. Hoover, Jr.		Address Myersville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis (c) Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Middletown	
21. I certify that I attended the deceased from Aug 18, 1959 , to Dec 26, 1959 , that I last saw the deceased alive on Dec 18, 1959 , and that death occurred at 7:25 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Elmer Harp		DATE SIGNED 12-27-59	
PHYSICIAN'S NAME (Type) J. Elmer Harp		ADDRESS (Street, city or town, state) Middletown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 29, 1959	
22c. NAME OF CEMETERY OR CREMATORY Grossnickle's		22d. LOCATION (City, town, or county) (State) Nr. Myersville Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle		ADDRESS Myersville, Md.	
24a. REC'D BY REGISTRAR DEC 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1941

RECEIVED
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

OFFICE OF THE
SECRETARY OF AGRICULTURE

1941

1

[Faint, mostly illegible text and signatures follow, including what appears to be a signature in the center and another at the bottom left.]

13727

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg,</u>				c. LENGTH OF STAY IN 1b <u>2 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Emmit Gardens</u>				d. STREET ADDRESS <u>Emmit Gardens</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Thomas</u> Last <u>Hornsby</u>				4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 27, 1879</u>	
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Thomas Hornsby</u>				14. MOTHER'S MAIDEN NAME <u>Hester Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-22-9065</u>			
17. INFORMANT <u>Betty H. Taylor</u>				Address <u>Emmit Gardens, Emmitsburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial degeneration -</u> <u>177x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prostatic Carcinoma</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive arteriosclerotic Cardiovascular Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>Dec 27</u> , 1959, that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>59</u> , and that death occurred at <u>6:30 P.</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Gettysburg, Pa.</u>				DATE SIGNED <u>Dec 27, 1959</u>			
ACTUAL SIGNATURE <u>Charles R. Williams</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Charles R. Williams</u>				<u>Gettysburg, Pa.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. George</u>		22d. LOCATION (City, town, or county) (State) <u>Pungoteague, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Wilson, Emmitsburg, Maryland</u>				24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

C. E. Wilson

CERTIFICATE OF DEATH

13781

Dec 1970

John Doe

Male

Age 65

White

Married

Single

John Doe

John Doe

John Doe

John Doe

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John Doe

13659 13687 Reg. Dist. No.

13659 13687 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 58 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 128 East Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clifton Middle Joseph Last Hoy				4. DATE OF DEATH Month December Day 14 Year 1959			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 4, 1901		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 58 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Construction		10b. KIND OF BUSINESS OR INDUSTRY Frederick		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Hoy				14. MOTHER'S MAIDEN NAME Nancy Stanton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Grace Hoy, 128 East Street, Frederick			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriolosclerotic Heart Disease (c) 1 year plus DUE TO cause last.							INTERVAL BETWEEN ONSET AND DEATH 10 Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B.O. Thomas				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-16-59		22c. NAME OF CEMETERY OR CREMATORY Frederick Co. Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Hicks				ADDRESS Frederick - Md.		24a. REC'D BY REGISTRAR DEC 17 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. BROWN		SEX Male	
AGE 35 Years		RACE White	
DATE OF DEATH January 15, 1925		PLACE OF DEATH Baltimore, Md.	
TIME OF DEATH 10:30 A.M.		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Clerk		MARITAL STATUS Single	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
MEDICAL HISTORY None		PRESENT ILLNESS None	
SIGNATURE OF EXAMINER J. H. Smith		SIGNATURE OF WITNESS J. H. Smith	
OFFICIAL SEAL (Seal of the State Department of Health)		OFFICIAL SEAL (Seal of the State Department of Health)	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13688

13700

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 237 West Patrick Street				d. STREET ADDRESS 237 West Patrick Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE DAVID WALTER SANDERS First Middle Last				4. DATE OF DEATH Month December Day 4 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1875		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Driver		10b. KIND OF BUSINESS OR INDUSTRY Fire Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Kolb				14. MOTHER'S MAIDEN NAME V. Saltzer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-10-5266		17. INFORMANT Address Mrs. Firbie V. Kolb-Sameas item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO (b) ARTERIO-SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Minutes Years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE B. O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) B. O. Thomas, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		1	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		12/4/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 7, 1959		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DEC 8 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1930

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES H. HARRIS		45		M		W		C	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
1234 E. BALTIMORE ST.		JAN 15 1930		HOME		HEART DISEASE		NATURAL	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		HISTORY	
CLOCK REPAIRER		HIGH SCHOOL		MARRIED		NONE		NONE	
SIGNED		DATE		PLACE		CAUSE		MANNER	
J. H. HARRIS		JAN 15 1930		HOME		HEART DISEASE		NATURAL	
WITNESSED		DATE		PLACE		CAUSE		MANNER	
J. H. HARRIS		JAN 15 1930		HOME		HEART DISEASE		NATURAL	

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 2 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 118 McMurray Street				d. STREET ADDRESS Ridge 18 X - 2			
3. NAME OF DECEASED (Type or print) First DAISY Middle ANNE Last LANGLEY				4. DATE OF DEATH Month December Day 17 Year 1959			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) yrs. 69	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nelson Barnes				14. MOTHER'S MAIDEN NAME Emily Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-32-3704		17. INFORMANT Address Mrs. Luzon W. Wars, Same as Item #1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, Pulmonary DUE TO Pulmonary Tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 years. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 15 minute	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Dec. 1 , 19 57 , to Dec. 17 , 19 59 , that I last saw the deceased alive on Dec. 17 , 19 59 , and that death occurred at 4:30 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard O. Thomas				ADDRESS (Street, city or town, state) Professional Building DATE SIGNED 12/18/59			
PHYSICIAN'S NAME (Type) B. O. Thomas, M.D.				Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 19, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		22d. LOCATION (City, town, or county) (State) St. Mary's County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE DEC 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12300

PLACE IN BOXES		STATION		DATE	
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1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 13728
 CERTIFICATE OF DEATH

13690

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Emmitsburg,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.#2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Joseph Daniel Lingg First Middle Last		4. DATE OF DEATH December 25, 1959 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1911
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Furniture Factory	
11. BIRTHPLACE (State or foreign country) Emmitsburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Felix Henry Lingg		14. MOTHER'S MAIDEN NAME Rosalia Brawner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 176-07-867	
17. INFORMANT Mrs. Gladys Lingg		Address Emmitsburg, Md. R.D.#2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 Dec , 19 59 , to 25 Dec , 19 59 , that I last saw the deceased alive on 25 Dec 59 , 19 59 , and that death occurred at 3:45 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE George L. Morningstar		ADDRESS (Street, city or town, state) Emmitsburg, Md.	
PHYSICIAN'S NAME (Type) GEORGE L. MORNINGSTAR, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 30, 1959	
22c. NAME OF CEMETERY OR CREMATORY New St. Joseph's		22d. LOCATION (City, town, or county) (State) Emmitsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson		ADDRESS Emmitsburg, Md.	
24a. REC'D BY REGISTRAR DEC 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CP

13738

CERTIFICATE OF DEATH

STATE OF NEW YORK

NAME -

AGE -

SEX -

RACE -

DATE OF BIRTH -

DATE OF DEATH -

PLACE OF BIRTH -

PLACE OF DEATH -

CAUSE OF DEATH -

DATE OF BURIAL -

PLACE OF BURIAL -

SIGNATURE OF DECEASED -

SIGNATURE OF WITNESSES -

SIGNATURE OF CLERK -

SIGNATURE OF JUDGE -

SIGNATURE OF SHERIFF -

SIGNATURE OF CORONER -

SIGNATURE OF DISTRICT ATTORNEY -

SIGNATURE OF COUNTY CLERK -

SIGNATURE OF TOWN CLERK -

SIGNATURE OF VILLAGE CLERK -

SIGNATURE OF POSTMASTER -

SIGNATURE OF SCHOOL SUPERVISOR -

SIGNATURE OF TOWN SUPERVISOR -

SIGNATURE OF VILLAGE SUPERVISOR -

SIGNATURE OF POSTMASTER GENERAL -

SIGNATURE OF SCHOOL COMMISSIONER -

SIGNATURE OF TOWN COMMISSIONER -

SIGNATURE OF VILLAGE COMMISSIONER -

SIGNATURE OF POSTMASTER GENERAL -

SIGNATURE OF SCHOOL COMMISSIONER -

SIGNATURE OF TOWN COMMISSIONER -

SIGNATURE OF VILLAGE COMMISSIONER -

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1027 North Market Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1027 North Market Street		d. STREET ADDRESS 1027 North Market Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MABEL Middle IRENE Last LINTON		4. DATE OF DEATH Month December Day 21 , Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1895
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR: Months 64 Days 21 Hours 21 Min. 1959	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Luther R. Staley		14. MOTHER'S MAIDEN NAME Alice Roberts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Lester S. Linton, 903 Motter Avenue, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ? Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Heart Disease DUE TO (c) 10+ years.		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/15 , 19 59 , to 12/28 , 19 59 , that I last saw the deceased alive on 12/28 , 19 59 , and that death occurred at 8:45 A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) East Church Street, DATE SIGNED 1/2/60	
ACTUAL SIGNATURE Richard C. Reynolds M.D.			
PHYSICIAN'S NAME (Type) R. C. Reynolds, M. D.		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 4, 1960	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JAN 5 '60	
		24b. REGISTRAR'S SIGNATURE Charles E. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13703

CERTIFICATE OF DEATH

13692

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CALVIN Middle S Last MARTIN				4. DATE OF DEATH Month Dec. Day 12 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1889		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY P.E. Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Martin				14. MOTHER'S MAIDEN NAME Elizabeth Holtz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-9007		17. INFORMANT Bessie M. Martin		Address Thurmont, Md. RD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/26 , 19 59 , to 12/12 , 19 59 , that I last saw the deceased alive on 12/12 , 19 59 , and that death occurred at 1300 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9 EAST CHURCH ST. FREDERICK, MD. DATE SIGNED 12/12/59							
ACTUAL SIGNATURE Richard C. Reynolds		PHYSICIAN'S NAME (Type) Richard C. Reynolds					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-15-59		22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE DEC 17 '59	
24b. REGISTRAR'S SIGNATURE William S. Kraus							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 Film G253 12-7-59 et
13729
CERTIFICATE OF DEATH

Reg. Dist. No.

13693

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Emmitsburg,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home				d. STREET ADDRESS West Main			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last John Tilden Miller				4. DATE OF DEATH Month Day Year December 2, 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1875		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Christopher Miller				14. MOTHER'S MAIDEN NAME Jane E. Eyler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-32-4984		17. INFORMANT Address Donald B Beard Emmitsburg Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis generalized DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 9 yrs. 7
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 23, 1959 , to Dec. 2, 1959 , that I last saw the deceased alive on Nov. 30, 1959 , and that death occurred at 4:10 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE M. Franklin Birely			ADDRESS (Street, city or town, state) Thurmont Md.		DATE SIGNED Dec. 2, 1959		
PHYSICIAN'S NAME (Type) M. FRANKLIN BIRELY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 4, 1959	22c. NAME OF CEMETERY OR CREMATORY New St. Joseph's		22d. LOCATION (City, town, or county) (State) Emmitsburg, Frederick Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Wilson				ADDRESS Emmitsburg, Md.		24a. REC'D BY REGISTRAR DATE DEC 4 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

CERTIFICATE OF DEATH

37528



1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12/1/31		5. PLACE OF BIRTH MOBILE, ALABAMA	
6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION None		10. EDUCATION High School	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Maryland		14. DATE OF DEATH 4/4/68		15. TIME OF DEATH 11:00 AM	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF CORONER J. Edgar Hoover		18. SIGNATURE OF WITNESS J. Edgar Hoover		19. SIGNATURE OF DECEASED J. Edgar Hoover		20. SIGNATURE OF NEXT OF KIN J. Edgar Hoover	
21. SIGNATURE OF REGISTRAR J. Edgar Hoover		22. SIGNATURE OF CLERK J. Edgar Hoover		23. SIGNATURE OF CHIEF OF POLICE J. Edgar Hoover		24. SIGNATURE OF DISTRICT ATTORNEY J. Edgar Hoover		25. SIGNATURE OF JUDGE J. Edgar Hoover	
26. SIGNATURE OF PROSECUTOR J. Edgar Hoover		27. SIGNATURE OF DEFENSE ATTORNEY J. Edgar Hoover		28. SIGNATURE OF JURY J. Edgar Hoover		29. SIGNATURE OF COURT J. Edgar Hoover		30. SIGNATURE OF JUDGE J. Edgar Hoover	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSES.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13704

CERTIFICATE OF DEATH

Reg. Dist. No. 13694

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital				e. STREET ADDRESS 230 East Third Street			
3. NAME OF DECEASED (Type or print) First ELMER Middle CLAYTON Last MINNICK				4. DATE OF DEATH Month December Day 18 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 16, 1893	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Brush Company		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles C. Minnick				14. MOTHER'S MAIDEN NAME Hannah C. Flook			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-10-2118		17. INFORMANT Mrs. Mary L. Minnick-Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Posterior Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from June , 19 58 , to Dec. 18 , 19 59 , that I last saw the deceased alive on Dec 17 , 19 59 , and that death occurred at 3:35A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Building DATE SIGNED 12/19/59							
ACTUAL SIGNATURE B. O. Thomas		M.D. Frederick, Maryland					
PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 21, 1959	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county)	(State)	Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE DEC 22 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12704

PLACE OF DEATH Baltimore, Maryland		COUNTY Baltimore	
NAME OF DECEASED John Doe		SEX Male	
DATE OF BIRTH January 1, 1900		AGE 25 years	
PLACE OF BIRTH Baltimore, Maryland		OCCUPATION Clerk	
MARITAL STATUS Single		CAUSE OF DEATH Heart Disease	
DATE OF DEATH December 15, 1925		TIME OF DEATH 10:00 AM	
PLACE OF DEATH Home		SIGNATURE OF DECEASED John Doe	
SIGNATURE OF WITNESS John Doe		SIGNATURE OF PHYSICIAN John Doe	
SIGNATURE OF CLERK John Doe		SIGNATURE OF REGISTRAR John Doe	

1

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND STATISTICS.

13730

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks		c. LENGTH OF STAY IN 1b 60 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks	
3. NAME OF DECEASED (Type or print) First NELLIE Middle DARCUS Last CLIPP		4. DATE OF DEATH Month December Day 17 , Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 2, 1870
9. AGE (In years last birthday) 89		IF UNDER 1 YEAR: Months 10 Days 18 Hours 30 Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Clipp		14. MOTHER'S MAIDEN NAME M. Hannah Clipp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. William H. Mohler, Jr.		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 yrs DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 14, 1959 to Dec 17, 1959 , that I last saw the deceased alive on Nov 24, 1959 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. G. F. Smith, M.D.		DATE SIGNED 12/18/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 19, 1959	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DEC 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13731

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Fred.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Myersville		c. LENGTH OF STAY IN 1b 5 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Melton Last Monroe, Sr.		4. DATE OF DEATH Month Dec. Day 9, Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1899
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) vice-president		10b. KIND OF BUSINESS OR INDUSTRY steamship line	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Franklin Monroe		14. MOTHER'S MAIDEN NAME Violet Melton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW I WW II 091-26-5663	
INFORMANT Helen Monroe, Myersville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 450.0 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 Hrs 5 Yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Alcoholism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-8 , 19 59 , to 12-9 , 19 59 that I last saw the deceased alive on 12-8 , 19 59 , and that death occurred at 9:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 12-11-59			
ACTUAL SIGNATURE Charles F. Hess M.D.		DATE SIGNED 12-11-59	
PHYSICIAN'S NAME (Type) Charles F. Hess M.D.		Smithsburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12-15-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		22d. LOCATION (City, town, or county) (State) Ft. Meyer, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR DEC 14 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

13732

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle G. Last Morningstar		4. DATE OF DEATH Month Dec. Day 18 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.	11. IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Philip Morningstar		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Philip Morningstar		Address Thurmont, RD 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease Congestive type 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 year			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Jan 15, 1959 to Dec 16, 1959 that I last saw the deceased alive on Dec 19, 1959 , and that death occurred at 3 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont-Md DATE SIGNED 12/19/59 ACTUAL SIGNATURE James K. Gray M.D. Thurmont-Md PHYSICIAN'S NAME (Type) James K. Gray			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-20-59	
22c. NAME OF CEMETERY OR CREMATORY Utica Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Greager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DEC 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13732



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurriness and bleed-through from the reverse side.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13733
CERTIFICATE OF DEATH

13698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Middletown</u> c. LENGTH OF STAY IN 1b <u>years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Middletown</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u>May</u> Last <u>Moser</u> 5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>4/27/1872</u> 9. AGE (In years lost birthday) <u>87</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____			4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>19 59</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Daniel Marker</u> 14. MOTHER'S MAIDEN NAME <u>Cynthia Bowman</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. <u>none</u> INFORMANT Address <u>Mrs. Harry Harshman, Middletown, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> <u>420.0</u> DUE TO (b) <u>Arteriosclerotic Heart disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____ 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____ 21. I certify that I attended the deceased from <u>10/1</u> , 19 <u>59</u> , to <u>12/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/17</u> , 19 <u>59</u> , and that death occurred at <u>4:30</u> P. M. from the causes and on the date stated above. ACTUAL SIGNATURE <u>Kenneth R. Henson</u> M.D. ADDRESS (Street, city or town, state) <u>Middletown, Md.</u> DATE SIGNED <u>12/18/59</u> PHYSICIAN'S NAME (Type) <u>Dr. Kenneth Henson</u> <u>Middletown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 22b. DATE THEREOF <u>12/21/1959</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Grossnickle Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Frederick Co. Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u> ADDRESS _____ 24a. REC'D BY REGISTRAR DATE <u>DEC 21 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12333

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and cause of death.

11

CERTIFICATE OF DEATH

Reg. Dist. No.

13699

13705

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 117 East 7th Street		d. STREET ADDRESS 117 East 7th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Arthur Last Nogle		4. DATE OF DEATH Month December Day 12 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1895
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 6 Days 12 Hours 12 Min.	11. IF UNDER 24 HRS. Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Steel Co. employee		10b. KIND OF BUSINESS OR INDUSTRY Frederick Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Nogle		14. MOTHER'S MAIDEN NAME Etta Belle Haugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 214-10-3391	
INFORMANT Mrs. Pauline Kline Nogle Address Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary emphysema DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April , 19 57 to 12/12 , 19 59 , that I last saw the deceased alive on 12/8 , 19 59 , and that death occurred at 11:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12-14-59			
ACTUAL SIGNATURE James B. Thomas M.D.			
PHYSICIAN'S NAME (Type) Dr. James B. Thomas M.D.		228 North Market St. Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-15-1959	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Darby Jr. Frederick, Maryland		24a. REC'D BY REGISTRAR DATE DEC 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

13702



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13700

13706

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS II6 carver Apt.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Larry Middle L Last Proctor				4. DATE OF DEATH Month December Day 3 Year 19 59					
5. SEX Male		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 29, 1949			
9. AGE (In years last birthday) 10 yrs.		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.		IF UNDER 24 HRS. Months 10 Days 10 Hours 10 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Proctor				14. MOTHER'S MAIDEN NAME Ruth Rebecca Edwards					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT William Proctor, Frederick, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchil asthma Asthma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 241X DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE B.O. Thomas				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) B.O. Thomas, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				January 3, 1959					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
BURIAL		12-6-59		BARTONSVILLE		Frederick-Co-Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III				ADDRESS Frederick-Md.		24a. REC'D BY REGISTRAR DATE DEC 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No.

13734

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#2				c. LENGTH OF STAY IN 1b 4 Years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#2				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Baker Valley Road			
d. STREET ADDRESS Baker Valley Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AUGUSTA Middle LOUISE Last RAY				4. DATE OF DEATH Month December Day 12 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 May 1894	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Benjamin F. Shelton				14. MOTHER'S MAIDEN NAME Annie R. Biser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unk		17. INFORMANT George F. Ray (Same as item #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Metastatic Carcinoma from DUE TO Adeno-carcinoma breast (c) 12 year				INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year 12 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 1 , 19 47 , to Dec. 12 , 19 59 , that I last saw the deceased alive on Dec. 11 , 19 59 , and that death occurred at 7 P. M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 228 N. Market St.				DATE SIGNED 14 Dec 1959			
ACTUAL SIGNATURE Bernard O. Thomas, Jr.				M.D. Frederick, Md.			
PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr., M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-16-59		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE DEC 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13707

CERTIFICATE OF DEATH

13702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>				c. LENGTH OF STAY IN 1b <i>1 day</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>MARIAN</i> Middle <i>L.</i> Last <i>RIPPEON</i>				4. DATE OF DEATH Month <i>Dec.</i> Day <i>4</i> Year <i>1959</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 8, 1910</i>	9. AGE (In years last birthday) <i>49 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Iyson Iregoning</i>				14. MOTHER'S MAIDEN NAME <i>Nora Mercer</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT Address <i>Mr. Wilmer E. Rippeon, Fred. R4, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carsonoma I Throat</i> <i>199.2</i> DUE TO <i>And lung</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>2 yrs</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 1, 1958</i> to <i>Dec 4, 1959</i> , that I last saw the deceased alive on <i>Nov 4, 1959</i> , and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Rocky Hill Cemetery W. Woodboro Md</i> DATE SIGNED <i>Dec 3, 1959</i>							
ACTUAL SIGNATURE <i>J. H. MESSLER M.D.</i>				DATE SIGNED <i>Dec 3, 1959</i>			
PHYSICIAN'S NAME (Type) <i>J. H. MESSLER M.D.</i>				DATE SIGNED <i>Dec 3, 1959</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/8/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Rocky Hill Cemetery</i>		22d. LOCATION (City, town, or County) (State) <i>W. Woodboro Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>S. C. Barton</i> ADDRESS <i>Walkeroville, Md.</i>				24a. RECEIVED BY REGISTRAR DATE <i>DEC 9 1959</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13708

CERTIFICATE OF DEATH

Reg. Dist. No.

13703

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rural --- Mt. Airy	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Three Pines Nursing Home		d. STREET ADDRESS R.D. # 2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helen First Roczynski Last		4. DATE OF DEATH Dec. Month 8 Day 1959 Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-7-1896
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? Austria	
13. FATHER'S NAME John Daneliuk		14. MOTHER'S MAIDEN NAME Mary Babych	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Address Mrs. Rodman Righter, Mt. Airy, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 443x DUE TO (with hemiplegia, left) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Vascular disease (c) 20 years		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 1, 1959 , to Dec. 8, 1959 , that I last saw the deceased alive on Dec. 8, 1959 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard O. Thomas Jr. M.D.		ADDRESS (Street, city or town, state) 228 N. Market St. Frederick, Md.	
PHYSICIAN'S NAME (Type) Bernard O. Thomas Jr.		DATE SIGNED Dec. 8, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-11-1959	
22c. NAME OF CEMETERY OR CREMATORY Linganore		22d. LOCATION (City, town, or county) (State) Unionville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR DATE DEC 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13704

CERTIFICATE OF DEATH

Reg. Dist. No.

13735

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knoxville		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Barbara Middle E Last Rohrback		4. DATE OF DEATH Month 12 Day 15 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 80 Days 15 Hours 19 Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Jacob Waters		14. MOTHER'S MAIDEN NAME Frances Owens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
INFORMANT Jesse Rohrback, Knoxville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) arterio-sclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 days 7			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/27/59 , 19 59 , to 12/15/59 , 19 59 , that I last saw the deceased alive on 12/15/59 , 19 59 , and that death occurred at 5:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Md. DATE SIGNED 12/15/59 ACTUAL SIGNATURE W. B. Carpenter M.D. PHYSICIAN'S NAME (Type) Dr. William B. Carpenter			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/17/1959	
22c. NAME OF CEMETERY OR CREMATORY Locust Valley Ch. of God Cem., Frederick Co., Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		24a. REC'D BY REGISTRAR DATE DEC 21 '59	
24b. REGISTRAR'S SIGNATURE Charles E. Kraus			

13732

WESTLAND STATE DEPARTMENT OF HEALTH - BIRMINGHAM 16

CERTIFICATE OF DEATH

13732

WESTLAND STATE DEPARTMENT OF HEALTH - BIRMINGHAM 16

13736

CERTIFICATE OF DEATH

13705

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#7				c. LENGTH OF STAY IN 1b 2 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Edgewood Church Road (Private home)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BARBARA Middle ALICE Last SHIFLER				4. DATE OF DEATH Month December Day 28 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 Feb 1883	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Washington County Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John W. Sensenbaugh				14. MOTHER'S MAIDEN NAME Amanda Hoover			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT 145 W. Broadway, Mrs. Ima S. Millen, Union Bridge, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Pancreas DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 week 6 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 4:20 a. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct. 1 , 19 59 , to Dec. 28 , 19 59 , that I last saw the deceased alive on Dec. 28 , 19 59 , and that death occurred at 4:20 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 228 N. Market St. DATE SIGNED 29 Dec 1959							
ACTUAL SIGNATURE Bernard O. Thomas, Jr. M.D.							
PHYSICIAN'S NAME (Type) Bernard O. Thomas, Jr.				Frederick, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-59		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE DEC 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12388

For District

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH Jan 15 1929		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. DISEASE OR INJURY Coronary Artery Disease		9. MANNER OF DEATH Natural	
10. SIGNATURE OF PHYSICIAN J. H. Harris		11. SIGNATURE OF WITNESSES J. H. Harris		12. SIGNATURE OF REGISTRAR J. H. Harris	
13. PLACE OF BIRTH Maryland		14. DATE OF BIRTH Jan 1 1864		15. SEX OF BIRTH Male	
16. OCCUPATION Farmer		17. EDUCATION High School		18. RELIGION Roman Catholic	
19. MARITAL STATUS Married		20. NAME OF SPOUSE Mary H. Harris		21. DATE OF MARRIAGE Jan 1 1885	
22. PREVIOUS MARRIAGES None		23. NAME OF PREVIOUS SPOUSE None		24. DATE OF PREVIOUS MARRIAGE None	
25. NAME OF PREVIOUS SPOUSE None		26. DATE OF PREVIOUS MARRIAGE None		27. NAME OF PREVIOUS SPOUSE None	
28. DATE OF PREVIOUS MARRIAGE None		29. NAME OF PREVIOUS SPOUSE None		30. DATE OF PREVIOUS MARRIAGE None	
31. NAME OF PREVIOUS SPOUSE None		32. DATE OF PREVIOUS MARRIAGE None		33. NAME OF PREVIOUS SPOUSE None	
34. DATE OF PREVIOUS MARRIAGE None		35. NAME OF PREVIOUS SPOUSE None		36. DATE OF PREVIOUS MARRIAGE None	
37. NAME OF PREVIOUS SPOUSE None		38. DATE OF PREVIOUS MARRIAGE None		39. NAME OF PREVIOUS SPOUSE None	
40. DATE OF PREVIOUS MARRIAGE None		41. NAME OF PREVIOUS SPOUSE None		42. DATE OF PREVIOUS MARRIAGE None	
43. NAME OF PREVIOUS SPOUSE None		44. DATE OF PREVIOUS MARRIAGE None		45. NAME OF PREVIOUS SPOUSE None	
46. DATE OF PREVIOUS MARRIAGE None		47. NAME OF PREVIOUS SPOUSE None		48. DATE OF PREVIOUS MARRIAGE None	
49. NAME OF PREVIOUS SPOUSE None		50. DATE OF PREVIOUS MARRIAGE None		51. NAME OF PREVIOUS SPOUSE None	
52. DATE OF PREVIOUS MARRIAGE None		53. NAME OF PREVIOUS SPOUSE None		54. DATE OF PREVIOUS MARRIAGE None	
55. NAME OF PREVIOUS SPOUSE None		56. DATE OF PREVIOUS MARRIAGE None		57. NAME OF PREVIOUS SPOUSE None	
58. DATE OF PREVIOUS MARRIAGE None		59. NAME OF PREVIOUS SPOUSE None		60. DATE OF PREVIOUS MARRIAGE None	
61. NAME OF PREVIOUS SPOUSE None		62. DATE OF PREVIOUS MARRIAGE None		63. NAME OF PREVIOUS SPOUSE None	
64. DATE OF PREVIOUS MARRIAGE None		65. NAME OF PREVIOUS SPOUSE None		66. DATE OF PREVIOUS MARRIAGE None	
67. NAME OF PREVIOUS SPOUSE None		68. DATE OF PREVIOUS MARRIAGE None		69. NAME OF PREVIOUS SPOUSE None	
70. DATE OF PREVIOUS MARRIAGE None		71. NAME OF PREVIOUS SPOUSE None		72. DATE OF PREVIOUS MARRIAGE None	
73. NAME OF PREVIOUS SPOUSE None		74. DATE OF PREVIOUS MARRIAGE None		75. NAME OF PREVIOUS SPOUSE None	
76. DATE OF PREVIOUS MARRIAGE None		77. NAME OF PREVIOUS SPOUSE None		78. DATE OF PREVIOUS MARRIAGE None	
79. NAME OF PREVIOUS SPOUSE None		80. DATE OF PREVIOUS MARRIAGE None		81. NAME OF PREVIOUS SPOUSE None	
82. DATE OF PREVIOUS MARRIAGE None		83. NAME OF PREVIOUS SPOUSE None		84. DATE OF PREVIOUS MARRIAGE None	
85. NAME OF PREVIOUS SPOUSE None		86. DATE OF PREVIOUS MARRIAGE None		87. NAME OF PREVIOUS SPOUSE None	
88. DATE OF PREVIOUS MARRIAGE None		89. NAME OF PREVIOUS SPOUSE None		90. DATE OF PREVIOUS MARRIAGE None	
91. NAME OF PREVIOUS SPOUSE None		92. DATE OF PREVIOUS MARRIAGE None		93. NAME OF PREVIOUS SPOUSE None	
94. DATE OF PREVIOUS MARRIAGE None		95. NAME OF PREVIOUS SPOUSE None		96. DATE OF PREVIOUS MARRIAGE None	
97. NAME OF PREVIOUS SPOUSE None		98. DATE OF PREVIOUS MARRIAGE None		99. NAME OF PREVIOUS SPOUSE None	
100. DATE OF PREVIOUS MARRIAGE None		101. NAME OF PREVIOUS SPOUSE None		102. DATE OF PREVIOUS MARRIAGE None	

NOTARY CLERK

THIS CERTIFICATE OF DEATH IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, ON JANUARY 15, 1929.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13706

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Virginia Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lander		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevens City 83X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Camp along Potomac River		d. STREET ADDRESS -	
3. NAME OF DECEASED (Type or print) CHARLES First Middle F. Last SNOOTS		4. DATE OF DEATH 12 Month 27 Day 1959 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-1909
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory		10b. KIND OF BUSINESS OR INDUSTRY Furniture	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Alonza L. Snoots		14. MOTHER'S MAIDEN NAME Katie Belle Jenkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-5947	
17. INFORMANT Mrs. Lettie Wetzell, Strawsburg, Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Minutes
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-59	
22c. NAME OF CEMETERY OR CREMATORY Lutheran		22d. LOCATION (City, town, or county) (State) Jefferson, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. L. Felt		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR DATE JAN 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. House	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED (Last, first, middle initial) _____		2. SEX OF DECEASED Male <input type="checkbox"/> Female <input type="checkbox"/>	
3. AGE OF DECEASED (Years, months, days) _____		4. DATE OF DEATH (Month, day, year) _____	
5. PLACE OF DEATH (City, town, village, or county) _____		6. TIME OF DEATH (Hour, minute) _____	
7. OCCUPATION OF DECEASED _____		8. CAUSE OF DEATH (Immediate) _____	
9. CAUSE OF DEATH (Underlying) _____		10. MANNER OF DEATH (Natural, Accidental, Suicidal, Homicidal) _____	
11. SIGNATURE OF MEDICAL EXAMINER _____		12. SIGNATURE OF WITNESSES _____	
13. DATE OF EXAMINATION _____		14. TIME OF EXAMINATION _____	
15. PLACE OF EXAMINATION _____		16. SIGNATURE OF REGISTRAR _____	
17. DATE OF REGISTRATION _____		18. TIME OF REGISTRATION _____	
19. PLACE OF REGISTRATION _____		20. SIGNATURE OF CLERK _____	
21. DATE OF CLERK'S SIGNATURE _____		22. TIME OF CLERK'S SIGNATURE _____	
23. PLACE OF CLERK'S SIGNATURE _____		24. SIGNATURE OF JURY _____	
25. DATE OF JURY SIGNATURE _____		26. TIME OF JURY SIGNATURE _____	
27. PLACE OF JURY SIGNATURE _____		28. SIGNATURE OF JUDGE _____	
29. DATE OF JUDGE SIGNATURE _____		30. TIME OF JUDGE SIGNATURE _____	
31. PLACE OF JUDGE SIGNATURE _____		32. SIGNATURE OF SHERIFF _____	
33. DATE OF SHERIFF SIGNATURE _____		34. TIME OF SHERIFF SIGNATURE _____	
35. PLACE OF SHERIFF SIGNATURE _____		36. SIGNATURE OF CORONER _____	
37. DATE OF CORONER SIGNATURE _____		38. TIME OF CORONER SIGNATURE _____	
39. PLACE OF CORONER SIGNATURE _____		40. SIGNATURE OF JURY _____	
41. DATE OF JURY SIGNATURE _____		42. TIME OF JURY SIGNATURE _____	
43. PLACE OF JURY SIGNATURE _____		44. SIGNATURE OF JUDGE _____	
45. DATE OF JUDGE SIGNATURE _____		46. TIME OF JUDGE SIGNATURE _____	
47. PLACE OF JUDGE SIGNATURE _____		48. SIGNATURE OF SHERIFF _____	
49. DATE OF SHERIFF SIGNATURE _____		50. TIME OF SHERIFF SIGNATURE _____	
51. PLACE OF SHERIFF SIGNATURE _____		52. SIGNATURE OF CORONER _____	
53. DATE OF CORONER SIGNATURE _____		54. TIME OF CORONER SIGNATURE _____	
55. PLACE OF CORONER SIGNATURE _____		56. SIGNATURE OF JURY _____	
57. DATE OF JURY SIGNATURE _____		58. TIME OF JURY SIGNATURE _____	
59. PLACE OF JURY SIGNATURE _____		60. SIGNATURE OF JUDGE _____	
61. DATE OF JUDGE SIGNATURE _____		62. TIME OF JUDGE SIGNATURE _____	
63. PLACE OF JUDGE SIGNATURE _____		64. SIGNATURE OF SHERIFF _____	
65. DATE OF SHERIFF SIGNATURE _____		66. TIME OF SHERIFF SIGNATURE _____	
67. PLACE OF SHERIFF SIGNATURE _____		68. SIGNATURE OF CORONER _____	
69. DATE OF CORONER SIGNATURE _____		70. TIME OF CORONER SIGNATURE _____	
71. PLACE OF CORONER SIGNATURE _____		72. SIGNATURE OF JURY _____	
73. DATE OF JURY SIGNATURE _____		74. TIME OF JURY SIGNATURE _____	
75. PLACE OF JURY SIGNATURE _____		76. SIGNATURE OF JUDGE _____	
77. DATE OF JUDGE SIGNATURE _____		78. TIME OF JUDGE SIGNATURE _____	
79. PLACE OF JUDGE SIGNATURE _____		80. SIGNATURE OF SHERIFF _____	
81. DATE OF SHERIFF SIGNATURE _____		82. TIME OF SHERIFF SIGNATURE _____	
83. PLACE OF SHERIFF SIGNATURE _____		84. SIGNATURE OF CORONER _____	
85. DATE OF CORONER SIGNATURE _____		86. TIME OF CORONER SIGNATURE _____	
87. PLACE OF CORONER SIGNATURE _____		88. SIGNATURE OF JURY _____	
89. DATE OF JURY SIGNATURE _____		90. TIME OF JURY SIGNATURE _____	
91. PLACE OF JURY SIGNATURE _____		92. SIGNATURE OF JUDGE _____	
93. DATE OF JUDGE SIGNATURE _____		94. TIME OF JUDGE SIGNATURE _____	
95. PLACE OF JUDGE SIGNATURE _____		96. SIGNATURE OF SHERIFF _____	
97. DATE OF SHERIFF SIGNATURE _____		98. TIME OF SHERIFF SIGNATURE _____	
99. PLACE OF SHERIFF SIGNATURE _____		100. SIGNATURE OF CORONER _____	
101. DATE OF CORONER SIGNATURE _____		102. TIME OF CORONER SIGNATURE _____	
103. PLACE OF CORONER SIGNATURE _____		104. SIGNATURE OF JURY _____	
105. DATE OF JURY SIGNATURE _____		106. TIME OF JURY SIGNATURE _____	
107. PLACE OF JURY SIGNATURE _____		108. SIGNATURE OF JUDGE _____	
109. DATE OF JUDGE SIGNATURE _____		110. TIME OF JUDGE SIGNATURE _____	
111. PLACE OF JUDGE SIGNATURE _____		112. SIGNATURE OF SHERIFF _____	
113. DATE OF SHERIFF SIGNATURE _____		114. TIME OF SHERIFF SIGNATURE _____	
115. PLACE OF SHERIFF SIGNATURE _____		116. SIGNATURE OF CORONER _____	
117. DATE OF CORONER SIGNATURE _____		118. TIME OF CORONER SIGNATURE _____	
119. PLACE OF CORONER SIGNATURE _____		120. SIGNATURE OF JURY _____	
121. DATE OF JURY SIGNATURE _____		122. TIME OF JURY SIGNATURE _____	
123. PLACE OF JURY SIGNATURE _____		124. SIGNATURE OF JUDGE _____	
125. DATE OF JUDGE SIGNATURE _____		126. TIME OF JUDGE SIGNATURE _____	
127. PLACE OF JUDGE SIGNATURE _____		128. SIGNATURE OF SHERIFF _____	
129. DATE OF SHERIFF SIGNATURE _____		130. TIME OF SHERIFF SIGNATURE _____	
131. PLACE OF SHERIFF SIGNATURE _____		132. SIGNATURE OF CORONER _____	
133. DATE OF CORONER SIGNATURE _____		134. TIME OF CORONER SIGNATURE _____	
135. PLACE OF CORONER SIGNATURE _____		136. SIGNATURE OF JURY _____	
137. DATE OF JURY SIGNATURE _____		138. TIME OF JURY SIGNATURE _____	
139. PLACE OF JURY SIGNATURE _____		140. SIGNATURE OF JUDGE _____	
141. DATE OF JUDGE SIGNATURE _____		142. TIME OF JUDGE SIGNATURE _____	
143. PLACE OF JUDGE SIGNATURE _____		144. SIGNATURE OF SHERIFF _____	
145. DATE OF SHERIFF SIGNATURE _____		146. TIME OF SHERIFF SIGNATURE _____	
147. PLACE OF SHERIFF SIGNATURE _____		148. SIGNATURE OF CORONER _____	
149. DATE OF CORONER SIGNATURE _____		150. TIME OF CORONER SIGNATURE _____	
151. PLACE OF CORONER SIGNATURE _____		152. SIGNATURE OF JURY _____	
153. DATE OF JURY SIGNATURE _____		154. TIME OF JURY SIGNATURE _____	
155. PLACE OF JURY SIGNATURE _____		156. SIGNATURE OF JUDGE _____	
157. DATE OF JUDGE SIGNATURE _____		158. TIME OF JUDGE SIGNATURE _____	
159. PLACE OF JUDGE SIGNATURE _____		160. SIGNATURE OF SHERIFF _____	
161. DATE OF SHERIFF SIGNATURE _____		162. TIME OF SHERIFF SIGNATURE _____	
163. PLACE OF SHERIFF SIGNATURE _____		164. SIGNATURE OF CORONER _____	
165. DATE OF CORONER SIGNATURE _____		166. TIME OF CORONER SIGNATURE _____	
167. PLACE OF CORONER SIGNATURE _____		168. SIGNATURE OF JURY _____	
169. DATE OF JURY SIGNATURE _____		170. TIME OF JURY SIGNATURE _____	
171. PLACE OF JURY SIGNATURE _____		172. SIGNATURE OF JUDGE _____	
173. DATE OF JUDGE SIGNATURE _____		174. TIME OF JUDGE SIGNATURE _____	
175. PLACE OF JUDGE SIGNATURE _____		176. SIGNATURE OF SHERIFF _____	
177. DATE OF SHERIFF SIGNATURE _____		178. TIME OF SHERIFF SIGNATURE _____	
179. PLACE OF SHERIFF SIGNATURE _____		180. SIGNATURE OF CORONER _____	
181. DATE OF CORONER SIGNATURE _____		182. TIME OF CORONER SIGNATURE _____	
183. PLACE OF CORONER SIGNATURE _____		184. SIGNATURE OF JURY _____	
185. DATE OF JURY SIGNATURE _____		186. TIME OF JURY SIGNATURE _____	
187. PLACE OF JURY SIGNATURE _____		188. SIGNATURE OF JUDGE _____	
189. DATE OF JUDGE SIGNATURE _____		190. TIME OF JUDGE SIGNATURE _____	
191. PLACE OF JUDGE SIGNATURE _____		192. SIGNATURE OF SHERIFF _____	
193. DATE OF SHERIFF SIGNATURE _____		194. TIME OF SHERIFF SIGNATURE _____	
195. PLACE OF SHERIFF SIGNATURE _____		196. SIGNATURE OF CORONER _____	
197. DATE OF CORONER SIGNATURE _____		198. TIME OF CORONER SIGNATURE _____	
199. PLACE OF CORONER SIGNATURE _____		200. SIGNATURE OF JURY _____	
201. DATE OF JURY SIGNATURE _____		202. TIME OF JURY SIGNATURE _____	
203. PLACE OF JURY SIGNATURE _____		204. SIGNATURE OF JUDGE _____	
205. DATE OF JUDGE SIGNATURE _____		206. TIME OF JUDGE SIGNATURE _____	
207. PLACE OF JUDGE SIGNATURE _____		208. SIGNATURE OF SHERIFF _____	
209. DATE OF SHERIFF SIGNATURE _____		210. TIME OF SHERIFF SIGNATURE _____	
211. PLACE OF SHERIFF SIGNATURE _____		212. SIGNATURE OF CORONER _____	
213. DATE OF CORONER SIGNATURE _____		214. TIME OF CORONER SIGNATURE _____	
215. PLACE OF CORONER SIGNATURE _____		216. SIGNATURE OF JURY _____	
217. DATE OF JURY SIGNATURE _____		218. TIME OF JURY SIGNATURE _____	
219. PLACE OF JURY SIGNATURE _____		220. SIGNATURE OF JUDGE _____	
221. DATE OF JUDGE SIGNATURE _____		222. TIME OF JUDGE SIGNATURE _____	
223. PLACE OF JUDGE SIGNATURE _____		224. SIGNATURE OF SHERIFF _____	
225. DATE OF SHERIFF SIGNATURE _____		226. TIME OF SHERIFF SIGNATURE _____	
227. PLACE OF SHERIFF SIGNATURE _____		228. SIGNATURE OF CORONER _____	
229. DATE OF CORONER SIGNATURE _____		230. TIME OF CORONER SIGNATURE _____	
231. PLACE OF CORONER SIGNATURE _____		232. SIGNATURE OF JURY _____	
233. DATE OF JURY SIGNATURE _____		234. TIME OF JURY SIGNATURE _____	
235. PLACE OF JURY SIGNATURE _____		236. SIGNATURE OF JUDGE _____	
237. DATE OF JUDGE SIGNATURE _____		238. TIME OF JUDGE SIGNATURE _____	
239. PLACE OF JUDGE SIGNATURE _____		240. SIGNATURE OF SHERIFF _____	
241. DATE OF SHERIFF SIGNATURE _____		242. TIME OF SHERIFF SIGNATURE _____	
243. PLACE OF SHERIFF SIGNATURE _____		244. SIGNATURE OF CORONER _____	
245. DATE OF CORONER SIGNATURE _____		246. TIME OF CORONER SIGNATURE _____	
247. PLACE OF CORONER SIGNATURE _____		248. SIGNATURE OF JURY _____	
249. DATE OF JURY SIGNATURE _____		250. TIME OF JURY SIGNATURE _____	
251. PLACE OF JURY SIGNATURE _____		252. SIGNATURE OF JUDGE _____	
253. DATE OF JUDGE SIGNATURE _____		254. TIME OF JUDGE SIGNATURE _____	
255. PLACE OF JUDGE SIGNATURE _____		256. SIGNATURE OF SHERIFF _____	
257. DATE OF SHERIFF SIGNATURE _____		258. TIME OF SHERIFF SIGNATURE _____	
259. PLACE OF SHERIFF SIGNATURE _____		260. SIGNATURE OF CORONER _____	
261. DATE OF CORONER SIGNATURE _____		262. TIME OF CORONER SIGNATURE _____	
263. PLACE OF CORONER SIGNATURE _____			

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13738

CERTIFICATE OF DEATH

13707

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Fred</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>I JAMSVILLE - P.O.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George Archie Snowden</u>				4. DATE OF DEATH <u>12 9 19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 21-1900</u>	9. AGE (In years lost birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer-Construction</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick Co - Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Md.</u>				13. FATHER'S NAME <u>Harce L Snowden</u>			
14. MOTHER'S MAIDEN NAME <u>Harriett Bowie</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>214-14-6569</u>				17. INFORMANT <u>Sadie N. Snowden</u> Address <u>I JAMSVILLE - Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema & bronchiectasis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 years.</u> <u>5 years.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/1/56</u> , 19 <u>56</u> , to <u>12/10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/10</u> , 19 <u>59</u> , and that death occurred on _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James P. Kern</u>				ADDRESS (Street, city or town, state) <u>Homascus, Md.</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED <u>12/10/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FOUNTAIN - MILLS</u>		22d. LOCATION (City, town, or county) (State) <u>Fred. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks</u> ADDRESS <u>Fred. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

13709

CERTIFICATE OF DEATH

Reg. Dist. No.

13708

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) 131 East Sixth Street		d. STREET ADDRESS 131 East Sixth Street	
3. NAME OF DECEASED (Type or print) First JESSE Middle BROWN Last SPANGLER		4. DATE OF DEATH Month December Day 27 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Jan 1907
9. AGE (In years less birthday) yrs. 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard	
11. BIRTHPLACE (State or foreign country) Floyd County Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James E. Spangler		14. MOTHER'S MAIDEN NAME Roseabelle Spangler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-24-5453	
17. INFORMANT Mrs. Bonnie R. Spangler (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-7 , 19 55 , to 12-27 , 19 59 , that I last saw the deceased alive on August 21, 1959 , and that death occurred at 12:20A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 220 N. Market St. DATE SIGNED 29 Dec 1959			
ACTUAL SIGNATURE Rex R. Martin		M.D. Frederick, Md.	
PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-30-59	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE DEC 30 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13739

CERTIFICATE OF DEATH

Reg. Dist. No.

13709

1. PLACE OF DEATH o. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Frederick</i>				c. LENGTH OF STAY IN 1b <i>9 yrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Monterose County Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>HENRY KEMPTON STOTTEMYER</i>				4. DATE OF DEATH Month Day Year <i>Dec. 25 19 59</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 29 1895</i>	9. AGE (In years last birthday) <i>64</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Line Plant</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John W. H. Stottemyer</i>				14. MOTHER'S MAIDEN NAME <i>Sarah L. Shelton</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>yes World War I</i>		16. SOCIAL SECURITY NO. <i>219-05-5175</i>		17. INFORMANT Address <i>Mr. Paul Stottemyer, Le Gore, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarct</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio Sclerosis</i> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i> <i>5 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <i>1954</i> , to <i>Dec 25</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Dec 1</i> , 19 <i>59</i> , and that death occurred at <i>7:50 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>H. H. Kline</i> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <i>Frederick Md 7.75 West St Dec 28 1959</i>			
PHYSICIAN'S NAME (Type) <i>H. H. Kline</i>				<i>Frederick Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/28/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Oak Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Le Gore Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>J. C. Barton Walkersville, Md</i>				24a. REC'D BY REGISTRAR DATE <i>DEC 29 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Charles L. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

3738

1-1-1914

DECEASED'S NAME [Faint text, possibly "JOHN J. ..."]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DECEASED'S RESIDENCE [Faint text, possibly "1234 ..."]		DECEASED'S OCCUPATION [Faint text, possibly "Teacher"]		DECEASED'S MARITAL STATUS [Faint text, possibly "Married"]	
DECEASED'S BIRTH DATE [Faint text, possibly "1868-10-15"]		DECEASED'S BIRTH PLACE [Faint text, possibly "Maryland"]		DECEASED'S RACE [Faint text, possibly "White"]	
DECEASED'S RELIGION [Faint text, possibly "Roman Catholic"]		DECEASED'S EDUCATION [Faint text, possibly "High School"]		DECEASED'S SERVICE [Faint text, possibly "None"]	
DECEASED'S CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		DECEASED'S MANNER OF DEATH [Faint text, possibly "Natural"]		DECEASED'S PLACE OF DEATH [Faint text, possibly "Home"]	
DECEASED'S DATE OF DEATH [Faint text, possibly "1914-11-10"]		DECEASED'S TIME OF DEATH [Faint text, possibly "10:00 AM"]		DECEASED'S PLACE OF BURIAL [Faint text, possibly "St. Mary's Cemetery"]	
DECEASED'S SIGNATURE [Faint signature]		DECEASED'S ADDRESS [Faint text, possibly "1234 ..."]		DECEASED'S CITY [Faint text, possibly "Baltimore"]	
DECEASED'S STATE [Faint text, possibly "Maryland"]		DECEASED'S COUNTY [Faint text, possibly "Baltimore"]		DECEASED'S ZIP CODE [Faint text, possibly "21201"]	
DECEASED'S SOCIAL SECURITY NUMBER [Faint text, possibly "123-45-6789"]		DECEASED'S MARITAL STATUS [Faint text, possibly "Married"]		DECEASED'S SERVICE [Faint text, possibly "None"]	
DECEASED'S CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		DECEASED'S MANNER OF DEATH [Faint text, possibly "Natural"]		DECEASED'S PLACE OF DEATH [Faint text, possibly "Home"]	
DECEASED'S DATE OF DEATH [Faint text, possibly "1914-11-10"]		DECEASED'S TIME OF DEATH [Faint text, possibly "10:00 AM"]		DECEASED'S PLACE OF BURIAL [Faint text, possibly "St. Mary's Cemetery"]	
DECEASED'S SIGNATURE [Faint signature]		DECEASED'S ADDRESS [Faint text, possibly "1234 ..."]		DECEASED'S CITY [Faint text, possibly "Baltimore"]	
DECEASED'S STATE [Faint text, possibly "Maryland"]		DECEASED'S COUNTY [Faint text, possibly "Baltimore"]		DECEASED'S ZIP CODE [Faint text, possibly "21201"]	
DECEASED'S SOCIAL SECURITY NUMBER [Faint text, possibly "123-45-6789"]		DECEASED'S MARITAL STATUS [Faint text, possibly "Married"]		DECEASED'S SERVICE [Faint text, possibly "None"]	

1. This certificate is to be filled out by the attending physician or the coroner, or by the registrar of vital statistics if the death is reported to him by the attending physician or the coroner.

2. The cause of death should be stated in full, and the manner of death should be stated in full.

3. The place of death should be stated in full.

4. The date of death should be stated in full.

5. The time of death should be stated in full.

6. The place of burial should be stated in full.

7. The signature of the attending physician or the coroner, or of the registrar of vital statistics, should be written in full.

8. The address of the deceased should be stated in full.

9. The city of the deceased should be stated in full.

10. The state of the deceased should be stated in full.

11. The county of the deceased should be stated in full.

12. The ZIP code of the deceased should be stated in full.

13. The social security number of the deceased should be stated in full.

14. The marital status of the deceased should be stated in full.

15. The service of the deceased should be stated in full.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13710

CERTIFICATE OF DEATH

Reg. Dist. No.

13710

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 106 West 12th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helen Summers		4. DATE OF DEATH 12 6 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-1-1911
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer for Department Store		10b. KIND OF BUSINESS OR INDUSTRY Frederick, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Lewis		14. MOTHER'S MAIDEN NAME Carrie Gossnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-10-3331	
17. INFORMANT Mr. Austin A. Summers		Address 106 W. 12th St. Frederick Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanotic Carcinoma 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma Ovary DUE TO (c) 1 1/2 yrs		INTERVAL BETWEEN ONSET AND DEATH 2 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1959 , to Dec 6 1959 , that I last saw the deceased alive on Dec 6 1959 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A T B RICE		DATE SIGNED 12/6/59	
PHYSICIAN'S NAME (Type) A T B RICE		ADDRESS (Street, city or town, state) Jefferson	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-1959	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dickey Jr.		ADDRESS Frederick, Maryland	
24a. REC'D BY REGISTRAR DEC 11 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hanes	

CERTIFICATE OF DEATH

12310

1. PLACE OF DEATH Home		2. COUNTY Baltimore	
3. STREET 100 W. 1st St.		4. CITY Baltimore	
5. STATE Maryland		6. ZIP CODE 21201	
7. DECEASED'S NAME John Doe		8. SEX Male	
9. DATE OF BIRTH 1-1-1911		10. AGE 58	
11. OCCUPATION Teacher		12. CAUSE OF DEATH Heart Disease	
13. DATE OF DEATH 1-15-1969		14. TIME OF DEATH 10:00 AM	
15. PLACE OF BIRTH Baltimore, Maryland		16. DATE OF DEATH 1-15-1969	
17. SIGNATURE OF DECEASED John Doe		18. SIGNATURE OF WITNESS John Doe	
19. SIGNATURE OF DECEASED John Doe		20. SIGNATURE OF WITNESS John Doe	
21. SIGNATURE OF DECEASED John Doe		22. SIGNATURE OF WITNESS John Doe	
23. SIGNATURE OF DECEASED John Doe		24. SIGNATURE OF WITNESS John Doe	
25. SIGNATURE OF DECEASED John Doe		26. SIGNATURE OF WITNESS John Doe	
27. SIGNATURE OF DECEASED John Doe		28. SIGNATURE OF WITNESS John Doe	
29. SIGNATURE OF DECEASED John Doe		30. SIGNATURE OF WITNESS John Doe	
31. SIGNATURE OF DECEASED John Doe		32. SIGNATURE OF WITNESS John Doe	
33. SIGNATURE OF DECEASED John Doe		34. SIGNATURE OF WITNESS John Doe	
35. SIGNATURE OF DECEASED John Doe		36. SIGNATURE OF WITNESS John Doe	
37. SIGNATURE OF DECEASED John Doe		38. SIGNATURE OF WITNESS John Doe	
39. SIGNATURE OF DECEASED John Doe		40. SIGNATURE OF WITNESS John Doe	
41. SIGNATURE OF DECEASED John Doe		42. SIGNATURE OF WITNESS John Doe	
43. SIGNATURE OF DECEASED John Doe		44. SIGNATURE OF WITNESS John Doe	
45. SIGNATURE OF DECEASED John Doe		46. SIGNATURE OF WITNESS John Doe	
47. SIGNATURE OF DECEASED John Doe		48. SIGNATURE OF WITNESS John Doe	
49. SIGNATURE OF DECEASED John Doe		50. SIGNATURE OF WITNESS John Doe	
51. SIGNATURE OF DECEASED John Doe		52. SIGNATURE OF WITNESS John Doe	
53. SIGNATURE OF DECEASED John Doe		54. SIGNATURE OF WITNESS John Doe	
55. SIGNATURE OF DECEASED John Doe		56. SIGNATURE OF WITNESS John Doe	
57. SIGNATURE OF DECEASED John Doe		58. SIGNATURE OF WITNESS John Doe	
59. SIGNATURE OF DECEASED John Doe		60. SIGNATURE OF WITNESS John Doe	
61. SIGNATURE OF DECEASED John Doe		62. SIGNATURE OF WITNESS John Doe	
63. SIGNATURE OF DECEASED John Doe		64. SIGNATURE OF WITNESS John Doe	
65. SIGNATURE OF DECEASED John Doe		66. SIGNATURE OF WITNESS John Doe	
67. SIGNATURE OF DECEASED John Doe		68. SIGNATURE OF WITNESS John Doe	
69. SIGNATURE OF DECEASED John Doe		70. SIGNATURE OF WITNESS John Doe	
71. SIGNATURE OF DECEASED John Doe		72. SIGNATURE OF WITNESS John Doe	
73. SIGNATURE OF DECEASED John Doe		74. SIGNATURE OF WITNESS John Doe	
75. SIGNATURE OF DECEASED John Doe		76. SIGNATURE OF WITNESS John Doe	
77. SIGNATURE OF DECEASED John Doe		78. SIGNATURE OF WITNESS John Doe	
79. SIGNATURE OF DECEASED John Doe		80. SIGNATURE OF WITNESS John Doe	
81. SIGNATURE OF DECEASED John Doe		82. SIGNATURE OF WITNESS John Doe	
83. SIGNATURE OF DECEASED John Doe		84. SIGNATURE OF WITNESS John Doe	
85. SIGNATURE OF DECEASED John Doe		86. SIGNATURE OF WITNESS John Doe	
87. SIGNATURE OF DECEASED John Doe		88. SIGNATURE OF WITNESS John Doe	
89. SIGNATURE OF DECEASED John Doe		90. SIGNATURE OF WITNESS John Doe	
91. SIGNATURE OF DECEASED John Doe		92. SIGNATURE OF WITNESS John Doe	
93. SIGNATURE OF DECEASED John Doe		94. SIGNATURE OF WITNESS John Doe	
95. SIGNATURE OF DECEASED John Doe		96. SIGNATURE OF WITNESS John Doe	
97. SIGNATURE OF DECEASED John Doe		98. SIGNATURE OF WITNESS John Doe	
99. SIGNATURE OF DECEASED John Doe		100. SIGNATURE OF WITNESS John Doe	

12310

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13713

CERTIFICATE OF DEATH

Reg. Dist. No.

13711

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 Terrace Avenue		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick d. STREET ADDRESS 11 Terrace Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marion Middle - Last Talbott		4. DATE OF DEATH Month 12 Day 20 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-26-1905
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 5 Days 10 Hours 10 Min.	11. IF UNDER 24 HRS. Months 5 Days 10 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Talbott		14. MOTHER'S MAIDEN NAME Minnie Holtman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Lawrence Talbott, Brunswick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Valvular Heart Disease 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Chronic DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6/168	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 17, 1958 to Dec 20, 1959 that I last saw the deceased alive on Dec 17, 1959 and that death occurred at 4 P M , from the causes and on the date stated above.			
ACTUAL SIGNATURE J.G.F. Smith		ADDRESS (Street, city or town, state) Brunswick, Md. DATE SIGNED 12/21/59	
PHYSICIAN'S NAME (Type) J.G.F. Smith		Brunswick, Md. 12/21/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-22-1959	
22c. NAME OF CEMETERY OR CREMATORY Park Heights		22d. LOCATION (City, town, or county) (State) Brunswick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Little		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR DEC 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

101

CERTIFICATE OF DEATH

1913

1

DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

PROFESSION

DATE OF DEATH

PLACE OF DEATH

101

DECEASED

AGE

SEX

1

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

PROFESSION

DATE OF DEATH

PLACE OF DEATH

[Handwritten signature]

[Handwritten signature]

101

DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

PROFESSION

DATE OF DEATH

PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13711

CERTIFICATE OF DEATH

Reg. Dist. No.

13712

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 4 East Church Street	
3. NAME OF DECEASED (Type or print) First MARY Middle EDITH Last THOMAS		4. DATE OF DEATH Month December Day 23 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1881
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Dr. Office	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cephus M. Thomas		14. MOTHER'S MAIDEN NAME Lauretta E. Schaeffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ruth T. Maisel		Address 707 Broadwood Road, Baltimore 29, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Cardiovascular dis. 422.1 DUE TO with dissecting aneurysm of thoracic and abdominal aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) and abdominal aorta DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 10+4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1951 to 12/23 , 19 59 , that I last saw the deceased alive on 22 DEC , 19 59 , and that death occurred at 10:05A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles H. Conley, Jr.		ADDRESS (Street, city or town, state) Professional Building DATE SIGNED 12/24/59	
PHYSICIAN'S NAME (Type) Charles H. Conley, Jr., M. D.		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 26, 1959	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE DEC 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Knead			

CERTIFICATE OF DEATH

13711

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. Dist. No.

PLACE OF BIRTH BALTIMORE, MARYLAND		PLACE OF DEATH BALTIMORE, MARYLAND	
DATE OF BIRTH JANUARY 1, 1900		DATE OF DEATH JANUARY 1, 1900	
SEX MALE		SEX MALE	
RACE WHITE		RACE WHITE	
OCCUPATION LABORER		OCCUPATION LABORER	
MARITAL STATUS SINGLE		MARITAL STATUS SINGLE	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
MEDICAL HISTORY NONE		MEDICAL HISTORY NONE	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF DECEASED [Signature]	
SIGNATURE OF WITNESS [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF CLERK [Signature]		SIGNATURE OF CLERK [Signature]	

This certificate is to be filled out by the physician or other person authorized by the State Department of Health. It is to be filed in the office of the State Department of Health, Baltimore, Maryland, and a copy is to be sent to the local health officer of the city or county in which the death occurred.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13745 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13713

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg		c. LENGTH OF STAY IN 1b 43 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Russell Bruce Tracey		4. DATE OF DEATH Month Day Year Dec. 11, 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 12, 1916
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lumber factory	
11. BIRTHPLACE (State or foreign country) Smithsburg RFD 1, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Peter Tracey		14. MOTHER'S MAIDEN NAME Levy Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW II		16. SOCIAL SECURITY NO. 216-14-6001	
17. INFORMANT Peter Tracey, Smithsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Concussion 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Fall Down 2 flight of Stairs (c) DUE TO cause lost.		INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell down flight of stairs at home + struck head.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. Dec. 11, 19 59		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Smithsburg - Frederick - Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12-13-59	
22c. NAME OF CEMETERY OR CREMATORY Bethel Church Cemetery		22d. LOCATION (City, town, or county) (State) Garfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE DEC 14 '59		Arthur S. Kline	

13741

CERTIFICATE OF DEATH

Reg. Dist. No.

13714

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW MARKET		c. LENGTH OF STAY IN 1b 30 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last VINNIE L. WARTHEN		4. DATE OF DEATH Month Day Year December 10 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 10 - 1922
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) MD
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN S. UMBERGER	
14. MOTHER'S MAIDEN NAME SARAH SHIPLEY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. —		17. INFORMANT Address MRS H. BERNARDSELY BY NEW MARKET MD	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		

21. I certify that I attended the deceased from October , 19 57 , to December , 19 59 , that I last saw the deceased alive on Nov 24 , 19 59 , and that death occurred at 4:30 PM , from the causes and on the date stated above.	
ACTUAL SIGNATURE W B Culwell	ADDRESS (Street, city or town, state) not diry, md
PHYSICIAN'S NAME (Type) W B, Culwell	DATE SIGNED 12/10/59

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC 13 - 1959	22c. NAME OF CEMETERY OR CREMATORY PLEASANT HILL CEM	22d. LOCATION (City, town, or county) (State) MONROVIA MD
23. FUNERAL DIRECTOR'S SIGNATURE Lucian K. Talon		24a. REC'D BY REGISTRAR DEC 17 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

WILLIAM C. BRYAN
AND
MILITARY

THE
UNITED STATES
OF AMERICA
DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13714

CERTIFICATE OF DEATH

Reg. Dist. No. 13715

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick				c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6 5th.Avenue				d. STREET ADDRESS 6 5th.Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nellie Middle May Last Wenner				4. DATE OF DEATH Month 12 Day 23 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-11-1890	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 6 Days 13 Hours 33 Min.		IF UNDER 24 HRS. Hours 33 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (None) FACTORY				10b. KIND OF BUSINESS OR INDUSTRY None SEWING		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Informant Address Mrs. Thelma Smith, Brunswick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Insufficiency 422.2 DUE TO Polio Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Polio DUE TO (c) Polio INTERVAL BETWEEN ONSET AND DEATH 6/59							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9/15 , 19 59 to 12/23 , 19 59 that I last saw the deceased alive on 12/11 , 19 59 , and that death occurred on 12/23 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Maryland DATE SIGNED 12/26/59 ACTUAL SIGNATURE [Signature] M.D. [Signature] PHYSICIAN'S NAME (Type) J.G.F. Smith Brunswick, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-59		22c. NAME OF CEMETERY OR CREMATORY Park Heights		22d. LOCATION (City, town, or county) (State) Brunswick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Fuchs Brunswick, Maryland				24a. REC'D BY REGISTRAR DEC 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hance	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13742 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13716

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Burkittsville</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Burkittsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Between Burkittsville and Jefferson</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph</u> <u>Richard</u> <u>Wood</u>		4. DATE OF DEATH Month Day Year <u>12</u> <u>30</u> <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-13-1915</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm etc.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Wood</u>		14. MOTHER'S MAIDEN NAME <u>Elsie R. Decker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>World War II</u>		16. SOCIAL SECURITY NO. <u>Morris R. Wood, Frederick, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot Wound of left side of face and</u> <u>976X</u> DUE TO <u>skull</u> Minutes Conditions, if any, which gave rise to immediate cause (b) <u>skull</u> (a), stating the underlying cause last. DUE TO (c) <u>skull</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>B.O. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B.O. Thomas</u>		DATE SIGNED <u>12/30/1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-2-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Taber</u>	22d. LOCATION (City, town, or county) (State) <u>Rockey Ridge</u> <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fete Faw. Bone</u>		ADDRESS <u>Brunswick, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Christina L. Howard</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MISSOURI MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]	
AGE [REDACTED]		RACE [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CITY OR TOWN WHERE DECEASED [REDACTED]		COUNTY [REDACTED]	
STATE [REDACTED]		ZIP CODE [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]	
MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]	
PREVIOUS ILLNESS [REDACTED]		MEDICATION [REDACTED]	
SURGICAL HISTORY [REDACTED]		ALLERGIC HISTORY [REDACTED]	
SOCIAL HISTORY [REDACTED]		PHYSICAL EXAMINATION [REDACTED]	
LABORATORY TESTS [REDACTED]		PATHOLOGICAL FINDINGS [REDACTED]	
TOXICOLOGY [REDACTED]		OTHER FINDINGS [REDACTED]	
SIGNATURE OF EXAMINER [REDACTED]		DATE [REDACTED]	